North Carolina Pharmacist

NCAP

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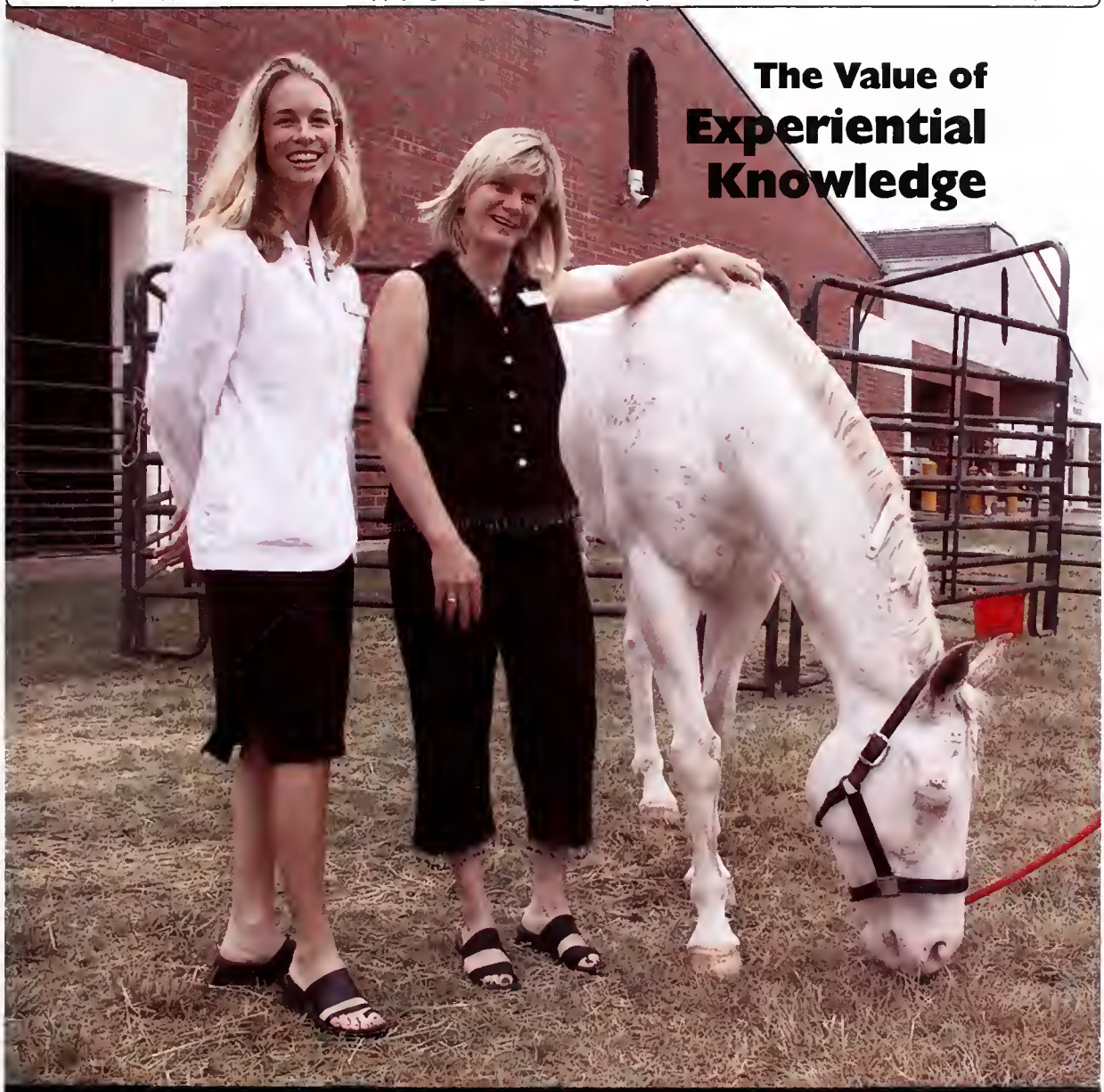

The Value of Experiential Knowledge

- Pharmacy Day in the Legislature, Feb. 23
- Acute Care Practice Forum Meeting, March 7-9

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On the Cover

UNC-Chapel Hill School of Pharmacy student Ryan Heaton with preceptor Gigi Davidson, RPh, at North Carolina State University's College of Veterinary Medicine.

Inside

Reminder: If you have not yet done so, please renew your NCAP membership for 2005 as soon as possible so you can continue taking advantage of great member benefits!

Fred Eckel

NCAP's Three-Year Strategic Plan

On November 28-29, 2004 the leadership of NCAP met to discuss the focus NCAP should take for the next few years. Davie Waggett, our President, challenged the Board to identify a few things that his presidency should focus on. His concern was that when you try to do too much, especially with limited resources, few things really get done.

On day one the session opened with dinner. Pharmacy leaders then shared their perspective on pharmacy's future. Speakers included Bruce Canaday, APhA President-Elect; Ross Brickley, ASCP Immediate Past President; Ralph Petri, COO, Kerr Drug; and Becky Snead, NCSPAE Executive Director. NCAP staff members followed with reports on the current status of their respective departments. On day two the participants were organized into small groups to answer the two questions: What are NCAP's goals for the next three years and what can NCAP do to accomplish these goals?

Based on this planning effort, is was decided that NCAP would focus on the following activities from 2005 to 2007:

Three-Year Strategic Plan

1. Work with the Board of Pharmacy to advance pharmacy practice.
2. Reorganize the Practice Forums to meet the unique needs of different pharmacy practitioners.
3. Promote patient care initiatives.
4. Promote Leadership Development.

Participants left the session feeling that a positive direction for NCAP was laid out. The Board and staff were assigned the following tasks and the Board will measure their progress.

2005 Implementation Plan

1. Address the relationship of NCAP with the Board of Pharmacy on behalf of the profession.

1.1 Notify the Board of Pharmacy of NCAP's desire to collaborate with them on practice issues. *-Executive Director/ President*
1.2 Attend Board of Pharmacy meetings and rules reviews to keep membership informed of activities. *-NCAP Staff*
1.3 Pursue medication safety initiatives as a collaborative effort between NCAP and NC Board of Pharmacy. *-President*
1.4 Implement the Tripartite Committee and evaluate its role in promoting collaboration. *-Tripartite Committee*

2. Revitalize the Practice Forums and Review Bylaws.

2.1 Work with NCASCP to merge with NCAP and become the Chronic Care Practice Forum. Use this model to guide NCAP's implementation to meet the new ASHP affiliation requirements for the Acute Care Practice Forum. *-Executive Director and Executive Committee*
2.2 Re-evaluate the Ambulatory Care Practice Forum to determine if it should be reorganized or divided into more sections. *-Ambulatory Care Practice Forum, Executive Committee*
2.3 Evaluate the need for a Technician Practice Forum. *-Technician Task Force*

In implementing this objective the Planning Committee suggested the following steps be followed by the Board:

A. Redefine the mission of each Practice Forum.
B. Reevaluate the current Practice Forums and determine if additions or deletions are needed.
C. Reevaluate NCAP's structure/alignment with national pharmacy organizations.
D. Consider extending more autonomy to each Practice Forum. Guidelines need to be set and monitoring of results is necessary.
E. Practice Forums need to develop a mission and action plans in line with NCAP's.

3. Promote Patient Care Initiatives

The Planning Committee recognized that pharmacists' roles needs to change to better meet patients' needs. NCAP can play a pivotal role in refocusing pharmacy practice on patient care. In many cases this will require NCAP to be flexible, respond to external initiatives and seek grant support. The elements of this objective will be refined and revised based on external opportunities.

3.1 Promote continuity of care initiatives that encourage pharmacists in different settings to collaborate on seamless patient care projects. *-Staff*
3.2 Collaborate and promote the pharmacist's role in administering vaccinations. *-Special Committee*
3.3 Communicate pharmacy services reimbursement opportunities such as Community Care Rx and offer educational programs where required. *-Education Council*
3.4 Continue to promote CPP's role in collaborative practice. *-CPP Committee, Staff*

4. Leadership Development

4.1 Continue Pharmacy Student Leaders Forum. *-Special Committee*
4.2 Include leadership development sessions at NCAP educational meetings. *-Education Council*
4.3 Revise Practice Forum structure to encourage involvement and leadership development. *-Bylaws Committee*

The Planning Committee recognized that other opportunities to promote leadership development for students, residents and new practitioners will occur. NCAP leadership and staff need to utilize these opportunities.

In implementing these initiatives the Planning Committee recognized that there are many NCAP activities that will continue such as member communication, educational programming and lobbying. All of these activities will be useful to promote the four NCAP initiatives for 2005-2007.

North Carolina Association of Pharmacists
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Dave Waggett

Dear NCAP Members,

The profession of Pharmacy is always, as it has been for many years, coming under scrutiny for what it is, and for what we think it will be in the near and the distant future. Changes in the profession have always been met with great resistance by some and great enthusiasm by others. Pharmacy laws and regulations have been enacted that reflect the current pharmacy practice standards, and enacted to help pharmacists and protect the health and welfare of the people we serve. Some of these are viewed as a help and some as a hindrance. Change has been constant, and for the most part, it has been good change. Health care is better than it has ever been, and medication is available to treat more disease symptoms than ever before, with better results and less side effects. Diverse opportunities for pharmacists are growing every year, as well as the need for more pharmacists. At the same time, managed care has become "mangled care."

So are we enjoying what we do as pharmacists? Do we let the technical things hang us up and steal our joy? We do good things for many of our patients, but do they go unnoticed? Do we allow some of the negative events, or "problems" to take away the joy of what we do? As a community pharmacist, how many patients have you helped in just one day, only to have those moments of accomplishment taken away in a moment by an irate customer, or a personnel problem. Don't let your joy of pharmacy be taken away. As a hospital, clinical, or consultant pharmacist, how many times have you reviewed patients' charts or made welcome recommendations that resulted in optimal patient outcomes, only to have those moments of accomplishment dashed by an insensitive colleague's comment that steals your joy?

Remember why you got into pharmacy in the first place. Most of you probably liked the thought of working in the medical field, and working directly with people to help them in some way. Pharmacy is the perfect profession for this type of personality. Please don't forget these reasons and strive every day to help someone with their medical needs and help improve outcomes for them. It's what we were trained to do, and we should do it without regard to all the things that try to get in our way. Be professional. Be caring. Be compassionate.

When we enjoy something in our lives, we usually try to participate in it more. If we love the game of golf, we join a golf team or country club. If we love to play tennis, we join a tennis team. If we love to fish, we buy a boat. If we love to fly, we buy a plane. SO, if you love the profession of pharmacy, and all the opportunities it can do for you, why wouldn't you join the organization that represents your profession in North Carolina? The answer is YOU SHOULD! NCAP needs YOU for the good of the profession, and YOU need NCAP for the good of YOUR profession. So please do it. Join in and participate because there are many opportunities. If this is your journal and you are reading this, then I am probably "preaching to the choir." So please pass this journal on to fellow pharmacist friends who are not NCAP members. There is much benefit to be gained.

In the year 2005, our plan is to become more aware of, and follow, NC Board of Pharmacy activities. The NCBOP is our governing and policy-making body and it is in our best interest to know what is going on. I personally plan on attending NCBOP meetings and other activities. NCAP also plans to revitalize and jumpstart the different pharmacy practice forums. When we united the Associations into one (NCAP), we included pharmacists from Acute Care settings, Chronic Care settings, and Ambulatory Care settings, as well as all other pharmacists in different work settings. NCAP must continue to meet the needs of all the different practice settings if we are to be a truly united association. It is one of the four priorities that we settled on in our strategic direction retreat. Patient care initiatives is another priority for this year. What can we do to make patient care better? Areas such as continuity of care, retooling pharmacists, vaccinations, better patient medication outcomes, and screenings will be some of the patient care initiatives that will be addressed and implemented in 2005. Leadership development is always important in order to make sure our work is continued. Good leaders provide vision and direction. NCAP must continue to encourage leaders and help equip them to lead.

So will you be a part of this move to take Pharmacy forward? I hope so. I invite you to join in, volunteer, and help make the practice of Pharmacy in North Carolina a better place in which to be a working pharmacist. Take pride in what you do, and get into the daily practice of helping others with their medication needs.

Happy New Year!

Davie Waggett, RPh
President

...applying drug knowledge to improve health

The Value of Experiential Knowledge

Views from North Carolina's Pharmacy Schools

Campbell U. School of Pharmacy

Students Truly Learn and Grow Through Experiential Education

Campbell University School of Pharmacy's Experiential Program begins in the first year of pharmacy school. During the first year, students participate in a "shadow program" and community health screenings. Early practice experiences commence in the summers between the first and second academic years, and advanced practice experiences in the fourth professional year.

After the first year of didactic work, most students complete a one month introduction to community pharmacy rotation. Between the second and third years, students complete a one month community rotation and a one month introduction to hospital rotation. Advanced practice experiences are conducted over the final year of the program and include the following: two months of internal medicine, one month of ambulatory care, one month of advanced community, one month of geriatric pharmacy, one month of drug information, and two months of electives. Many of the preceptors for the six required advanced practice experiences are pharmacy practice faculty (full-time faculty or adjunct/clinical faculty).

The goal of the experiential program is to provide a structured, practical, and closely supervised professional experience that enables the student to better assume his/her future role as a competent pharmacist. This goal includes the development of professional judgment, practice competency and technical skills.

In order to establish student competency and confidence in the realm of pharmacy practice, the experiential program has the following objectives:

• Provide practical experience in the operation and management of a community or hospital pharmacy and/or drug distribution system.

• Aid in the development of communication skills so that the student can interrelate effectively with the patient and health care professionals.

• Instill recognition of the continuous need to grow professionally in order to maintain/enhance personal competency and skills.

• Introduce the student to advanced patient care skills that will accrue benefit to patients regardless of practice site.

• Train the student to apply clinical and scientific knowledge in daily practice.

• Provide the student opportunities to engage in scholarly activities, e.g., special projects, in-service presentations, research activities, and others.

• Provide practical experience in the operation and management of advanced specialty practices, e.g., drug information, pharmacokinetics, pharmacy consult service, infectious disease service, research service, and others.

Students are evaluated by each preceptor and receive a letter grade for each advanced practice experience rotation (the early practice experiences are graded as a "pass/fail"). Preceptors use a specific grading tool that is tailored to each type of rotation. For example, the evaluation form for the advanced community rotation will allow the preceptor to assess if the student has met specific goals and objectives related to successful practice in a community pharmacy. The evaluations may then be submitted online.

Campbell University School of Pharmacy and the Office of Experiential Education sponsor various continuing education programs for preceptor pharmacists across our state. Since many of the pharmacists that precept our students also precept for other schools, we have co-sponsored various preceptor training programs with both UNC and Wingate Schools of Pharmacy.

As Director of the Experiential Program, I would like to continue to increase the opportunities that our students have to experience the various facets of the pharmacy world. I believe that students truly learn and grow while completing their experiential education. Providing various and numerous opportunities to our students during their advanced practice experiences will help shape a stronger future for the pharmacy profession.

-Valerie Britt Clinard, PharmD
Director of Experiential Programs
Assistant Professor of Pharmacy Practice
Campbell University School of Pharmacy

Take the Challenge, Share Your Knowledge and Precept

I have precepted students for 13 years; this includes my residency year and the five years I spent as a clinical pharmacy specialist before taking my current position with Campbell. I really enjoy sharing with students my passion for the field of pharmacy and for the geriatric population. I also like learning from them.

As a preceptor, my greatest challenge is balancing my clinical and precepting responsibilities. I am blessed, as full-time faculty, that my primary responsibility is precepting students. However, I also have an obligation to the patients and healthcare team that I serve. I think students observing how I balance these and other items, such as classroom lectures and scholarly activities, illustrates the importance of time management and shows them that a pharmacist's job is not always "9 to 5."

I precept approximately 24 students a year; I generally have three students a month for eight months. I actually prefer having more than one student at a time because it is good for them to work with their colleagues.

Overall, I believe students are well-prepared for their rotations. I often perceive their biggest challenges as learning the intricacies of the rotation site, trying to process the medical complexity of their patients, and trying to determine what is significant.

One of the hardest parts of my job is effectively evaluating students. To help in this process, I inform students that it is their responsibility to show me what they know. This sometimes motivates those who may not routinely speak out. For those who do not speak out, I ask plenty of questions! I also make the students responsible for patient care activities. Students learn that the

pharmacist is an integral part of the interdisciplinary care team. This accountability usually encourages them to work harder. I always do a midpoint evaluation with students and pre-midpoint if the situation warrants. During the midpoint and final evaluation I use Campbell's Clerkship Evaluation Form, and I find this form to be helpful in covering all of the major areas of learning. With Campbell's grading scale (C or above is passing), a grade of "C" is for the average student; while an "A" is for the exceptional one. In addition to patient care activities, students are also required to do a number of projects during their rotation, e.g., new drug facts, therapeutics talk, written drug information questions, and case presentations.

I strongly encourage pharmacists to become preceptors! While it may be a lot of work, it can be very rewarding. The NC Board of Pharmacy recognizes precepting as worthy of continuing education credit (if you are still looking for reasons to precept). Being a preceptor has helped me stay current with medical literature and given me the opportunity to work with some very fine people. Students will often challenge you, and may even occasionally frustrate you, but knowing that you have shared your knowledge and passion for what you do with others, and seeing that same "spark" in a student, makes it all worthwhile!

Preceptor Joy Greene (white coat) and her staff (l to r) Sandy Curlee, Lisa Lowder, and Rose Smith.

- Tina Harrison Thornhill, PharmD, FASCP, CGP
Associate Professor of Pharmacy Practice
Campbell University School of Pharmacy
Clinical Site: Wake Forest University Baptist Medical Center, Winston-Salem, NC

A Refreshing Change of Pace From the Classroom

As a fourth-year pharmacy student, I have enjoyed many new and interesting opportunities provided by Campbell University's experiential learning program. These practical experiences have been a refreshing change of pace from the traditional classroom setting. Now, test taking and lectures have been replaced by presentations and patient care activities. Through these practical experiences I have been able to improve my clinical skills, literature evaluation abilities, and comfort with public speaking. My exposure to a variety of learning opportunities in different pharmacy practice settings has been excellent career preparation.

My fourth-year rotations began with internal medicine, which is considered to be one of the most challenging experiences of pharmacy school. During that month I had many opportunities to learn pharmacy practice skills in the hospital. I spent the days rounding with the medical team, meeting with our pharmacy mentors to discuss patient cases, and preparing journal club and case study presentations. As a part of the medical team, I performed pharmacokinetics calculations and monitored medication regimens for interactions, adverse effects, and therapeutic efficacy. This rotation gave me a better understanding of how pharmacists working in a clinical role can make a positive impact on patient care.

Another learning opportunity I benefited from was assisting in a pharmacist-managed clinic where I saw patients with diabetes, hypertension, and hyperlipidemia. Along with the pharmacists in this clinic, I introduced patients to the proper use of glucometers, counseled patients on their medications, educated patients about a healthy lifestyle, and made therapeutic recommendations to physicians. It was great to see community pharmacists using their clinical skills and spending significant time helping patients learn more about their health.

I was also able to assist a pharmacist with a nursing home consultation. This was something I learned about in pharmacy law and I was excited about experiencing consulting firsthand. The consultation required careful review of the patients' charts for therapeutic dilemmas often seen in geriatric practice. When medication-related problems were noted, we made recommendations to the facility's medical staff. Although I had not thought of nursing home consulting as a future career prior to this rotation, I now see it as a challenging and interesting career option.

As I approach the end of my rotation schedule I can offer some advice for future students. Rotations can be a stressful time due to a self-imposed pressure to succeed. You may become discouraged when you cannot remember all of amiodarone's side effects, or maybe you have a fear of public speaking. Instead of being frustrated when you do not know all of the answers, or fearful of uncomfortable situations, try to embrace these learning opportunities. You get the most out of clerkships when you have a positive attitude and realize that what you do not know today, you will be sure to know tomorrow.

- Benji Small
PharmD Candidate, Class of 2005
Campbell University School of Pharmacy

UNC School of Pharmacy

Clerkships Consistantly Rated as Highlight of Education

The primary goal of the UNC School of Pharmacy Professional Experience Program is to assure that each pharmacy student develops the technical skills, knowledge, application skills, professional judgment, communication skills and competency necessary for entry into the profession of pharmacy. A professional skills/clinical practice continuum begins in the first semester of the first year of the curriculum and continues through the fourth year. Students learn to apply their classroom knowl-

continued page 8

edge of pharmacotherapy, pharmacokinetics and pharmaceutics by providing pharmaceutical care for patients under the supervision of a preceptor. During experiential training, students strengthen their drug therapy knowledge and improve their clinical decision- making skills in a real world setting.

Each UNC pharmacy student must complete six required and four elective rotations. The required rotations are in community pharmacy, hospital pharmacy, general medicine, ambulatory care, and medicine specialty. During the summer following the first-year curriculum, students are placed in community and hospital pharmacies (two weeks each) to provide early exposure to pharmacy practice and positive role models. Following the second-year curriculum, students participate in either a month-long advanced hospital or advanced community clerkship. Students complete a second advanced community or hospital clerkship in the PY4 year, in the setting not previously explored. The remainder of the PY4 year focuses primarily on clinically-oriented patient care clerkships. Students are graded on an honors/pass/fail basis during all clerkships.

Kim Leadon, Director of Experiential Education at UNC-Chapel Hill, helps pharmacy student Nichole Jennings research clerkship opportunities in the experiential education data base.

The Clinical Scholars Program provides a challenging combination of clinical experiences that are highly mentored, structured, and seminar-intensive. Students admitted to the program for their final year may select rotations with either an inpatient or ambulatory care focus. The Clinical Scholars Program requires students to handle responsibilities that resemble those in a post-graduate residency program, including a research project, seminars with faculty and clinical specialists, presentations, and close work with a mentor.

Clerkship students are distributed across North Carolina through a statewide network of Area Health Education Centers (AHEC). This network provides students access to approximately 500 active preceptors in nearly 300 practice sites. The majority of sites are located in North Carolina, however, students have access to approximately 40 affiliated sites across the United States. Objectives of the North Carolina Area Health Education Centers Program are to increase the quantity, ensure the quality and improve the geographic distribution of health professionals in all 100 counties of the state. Pharmacy students work in small groups throughout the advanced practice clerkships with faculty mentors in the AHEC's. AHEC pharmacy faculty members coordinate, supervise and mentor pharmacy students in their experiential learning. They also assist North Carolina pharmacists in improving the quality of pharmaceutical care provided to their patients through continuing education programming and one-to-one consultation. The AHEC Program offers an ideal mechanism through which the school's Professional Experience Program can be most effectively coordinated and administered. The AHEC's provide student housing, classrooms and seminar rooms, and extensive health science libraries for student, faculty, and practitioner use.

The UNC experiential training program relies on volunteer preceptors who desire to contribute to the future of the profession of pharmacy by sharing their time and expertise with pharmacy students. It is crucial that preceptors feel comfortable in their role as teacher and mentor and are able to structure organized clerkships with adequate learning opportunities. In addition, preceptors are expected to provide routine feedback, evaluate the learner's performance according to goals and objectives for the clerkship, and manage difficult student issues as they arise.

The UNC School of Pharmacy and AHEC-based Departments of Pharmacotherapy assist preceptors in clerkship development, clinical teaching strategies and student performance appraisal skills through training workshops and ongoing support. Additionally, UNC preceptors are given free access to all of UNC-Chapel Hill's licensed online pharmacy resources via the AHEC Digital Library which includes many valuable tools for clinical practice, research, teaching and continuing education.

The UNC School of Pharmacy recognizes the tremendous contribution of those who serve as preceptors and the critical role they play in the education and development of our students. Students consistently rate clerkship experiences as a highlight of their pharmacy education. Students come back from rotations more mature and more professional, with new confidence in their skills and knowledge in large measure from what preceptors have instilled in them.

The UNC School of Pharmacy is eager to establish long-term relationships with experienced pharmacists who are willing to impart professional knowledge and guide pharmacy students through on-site experiential education.

- Kim I. Leadon, M.Ed.
Director, Office of Experiential Education
Clinical Assistant Professor
University of North Carolina at Chapel Hill School of Pharmacy

Precepting Requires Preparation, Commitment and Balance

My father was an educator. He taught science and I saw how rewarding his career was for him. He would get so excited when able to reach a student with a new concept, a new experience, or when he would see the student's full potential and know they were moving in the right direction. Growing up with this type of role model made me realize it's not always how much you know, but how you communicate and how well you adapt to other learning styles. I saw firsthand how a good teacher could change a person's life.

When I became a pharmacist an opportunity arose for me to become a preceptor for UNC. I personally had some disappointing clinical rotations while in pharmacy school and thought that if I ever taught I would do things a bit differently. I felt that most people retain knowledge best when there is an association or strong emotion at-

tached to the concept. Connecting students to patients in some way makes concepts more tangible and easier to remember than abstract examples or text readings alone.

For me the greatest challenge of being a preceptor has been the balance between keeping my work up to date and providing quality educational opportunities for my students. In addition to the time management skills required, I have seen an assortment of work styles and varying degrees of preparedness from the students I've precepted. This is also a challenge in that one must individualize the rotation experience and change how one interacts and directs a student. The pharmacy curriculum is mostly the same for all. I'm convinced the preparedness of a student on rotation has more to do with motivation and maturity than knowledge alone.

UNC provides resources and support for preceptors. From the AHEC Digital Library, workshops and personal guidance with individual students, the experiential educational staff has provided an excellent support structure to accomplish the goals of being a preceptor.

The end point of a rotation is the student evaluation. This is a difficult task for a preceptor but, the most important. It must be done honestly and constructively. It should be taken very seriously. Students should be made aware of areas in which they fall short as early as possible in the rotation in order to make the corrections needed to successfully complete the rotation. If these corrections are not made and the student has not fulfilled his/her obligations or shown they are knowledgeable in required areas then the preceptor must report these findings and accurately complete the evaluation.

I've truly benefited from being a preceptor and have learned much from my students. Being a preceptor is a rewarding experience but it requires preparation and commitment.

- Lori Cohn Edwards, PharmD, FASCP
Consultant Pharmacist
Neil Medical Group

Pharmacy as Art: A Masterpiece of Effective Healthcare

My fourth year in pharmacy school has been the most rewarding period of my academic life. I have gained more knowledge about human beings, the art of pharmacy and the health care system as a whole than I thought was possible. This is all thanks to the UNC Chapel Hill School of Pharmacy experiential program.

Looking back at the first three academic years of pharmacy school, I can now see that I was only laying a foundation for my fourth year of rotations. I remember thinking that I knew all I could know about cardiology, asthma and diabetes before I took my exams. However, when I started my rotations, my whole outlook on pharmacy changed. What was missing all those years were the patients. I used to think that pharmacy was a science. Now that I have had the wonderful opportunity of interacting with patients, I realize that pharmacy is an art. It's not about matching a medication to a disease state and hoping that it works. Instead, it is a process that involves a skillful, caring person integrating the patient, as an individual, (their history, medications, current disease state, and other healthcare disciplines) into a masterpiece of effective healthcare. This is what the experiential program is teaching me to do.

I have found that I learn more about disease states and medications by the interactions between pharmacists, physicians and patients. I am able to better understand the importance of lab values, physical assessment and patient interviews because I am applying these practices to an actual human being. I think what students miss during those years of academic work is the value of clinical experience, interdisciplinary opinion and patient contact. In my opinion, it would be beneficial if there could be more time devoted to experiential training. I feel students would have a better idea of what they would like to do with their career, as well as have the confidence to practice pharmacy in any setting.

There are many students that view their fourth year as an obstacle to graduating. My advice is to go into your fourth year with an open mind. Remember that this year is the time to get out of pharmacy school what you have put in. Learn what you want to learn, don't be afraid to ask questions, and explore areas you don't understand that may intimidate you. I have been able to observe a craniotomy, procedures in the catheter lab, and enjoy the satisfaction of teaching a patient how to manage their medications. This is what I wanted to get out of my experience. Go into your fourth year asking yourself what you want to get out of your experience, and make sure that it is accomplished before you graduate.

- Michele DeMarco
PharmD Candidate, Class of 2005
UNC School of Pharmacy

Wingate U. School of Pharmacy

Wingate University enrolled its inaugural pharmacy class in August, 2003. Despite the fact that the first graduation is more than two years away, Wingate's commitment to experiential training is already evident. The School of Pharmacy distinguishes between Early Practice Experience (EPE), which occurs during the first two years of the curriculum, and Advanced Practice Experience (APE) which occurs during the third and fourth years. These two aspects of training are vastly different in terms of purpose and design, but both reflect the high priority given to experiential education at Wingate. As evidence of that fact, the School of Pharmacy employs two Directors of Practice Experience among the 15 current faculty members.

The Wingate University Early Practice Experience Program

Wingate University has taken a new approach to experiential training. During the first three years of the curriculum, rather than schedule practice experience around didactic coursework, the two educational components have been integrated to occur simultaneously during the semester. As a result, students are better able to relate what they experience at the pharmacy to what they are learning in the classroom. The synergistic learning processes that result are in line with the primary goals of Wingate's Early Practice Experience program.

The purpose of EPE extends far beyond providing students an opportunity to develop specific pharmacy practice skills. EPE enables students to explore how pharmacy systems function, in order to understand applications of their growing scientific and clinical knowledge. Secondly, EPE provides students with direct exposure to the dynamics of the pharmacy work environment and guides them to a realistic appreciation of the challenges that confront pharmacists on a daily basis. Thirdly, EPE facilitates each student's development of key professional values.

Such goals require a coordinated training program that focuses on much more than work experience. EPE occurs during the semester as part of the planned course, rather than during the summer. Preceptors mentor students in conjunction with an on-campus course instructor. All students are required

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to complete a standardized set of weekly assignments. Students also meet weekly on campus as a group and make weekly entries in a journal to reflect on what they've experienced.

A one-semester EPE course is offered during each of the first two years of the curriculum. The two EPE courses are offered during the fall and spring semesters, accommodating approximately half of the class (30 students) each time. During the first EPE course each student trains in a local community pharmacy for three to four hours in the afternoon, twice a week for 14 weeks. The second EPE course, offered during the second year, involves training in a hospital pharmacy for a four hour period every week for 14 weeks.

Currently there are 46 community pharmacies and 12 hospital pharmacies affiliated with Wingate for EPE training. All are within an hour drive of the Wingate campus.

- Dan Brown, PharmD
Director of Early Practice Experience
Wingate University School of Pharmacy

The Wingate University Advanced Practice Experience Program

The Advanced Practice Experience Program, to begin in August 2005, takes place during the final two years of pharmacy school. The third-year component will consist of one rotation in both the fifth and sixth semesters encompassing approximately 140 hours of experiential training. The goal of the third-year APE is the demonstration of basic clinical skills in the inpatient and ambulatory care settings. The rotations transpire during the school year, affording a teaching partnership between the pharmacy school and the pharmacy site. This approach to education will optimize knowledge and build a solid foundation for the fourth-year advanced practice experience.

The entire fourth-year is devoted to full-time rotations that provide approximately 1,900 hours of experiential training. The combined hours of the early and advanced practice experiences at Wingate University School of Pharmacy are among the highest in the United States. Numerous applicants to the school of pharmacy cite the prominence of experiential training to be a key factor in the decision to apply. Required fourth-year rotations include advanced community practice, advanced institutional practice, ambulatory care practice, inpatient internal medicine, and long-term care practice. There are also ample opportunities for special elective rotations tailored to the needs and interests of the student. Examples include compounding pharmacy, home infusion pharmacy, radionuclear pharmacy, pharmaceutical industry, pharmaceutical associations, veterinary pharmacy, pharmacy management, and a variety of specialized acute care and ambulatory care settings.

Wingate student Lauri Saleeby developing her professional skills at Eckerd Drugs in Monroe, NC.

The development of regions for advanced experiential education is ongoing. In addition to the Charlotte area, experiential sites will be located in Union County, Cabarrus County, and Asheville, North Carolina. Preceptors will include on-campus faculty as well as clinical pharmacy practitioners who are awarded faculty appointment at the Clinical Assistant or Associate level.

- Lisa Smith, PharmD
Director of Advanced Practice Experience
Wingate University School of Pharmacy

Precepting Students Can Help You Be a Better Pharmacist

I have desired to be a preceptor ever since I was a pharmacy student migrating from one rotation site to another. As a student I had many preceptors, some were helpful and some were not. I vowed as a fourth-year pharmacy student that I would become a preceptor and I would be a "good" preceptor, being helpful at all times to my students.

I have found there are many challenges to being an effective preceptor. The biggest for me is time management. Sometimes the workload in the pharmacy is heavy and it is hard to find time to teach students. There are also challenges from unmotivated students who only want to do the minimum amount of work to get by. These students are not as apt to jump in and help out with daily pharmacy tasks. One last challenge is tailoring a student's rotation at my pharmacy based from their previous experience. Some students come to me with a lot of pharmacy experience while others have never stepped foot behind the counter.

Wingate's program is different from other programs. Students begin pharmacy practice from day one. I really like this format. It gives students a chance to put into practice what they are learning in the classroom. This definitely enhances their learning experience.

Wingate gives preceptors a huge amount of support. We are highly informed when it comes to their expectations of us in this program. I value the manual we are given to guide us while teaching students. Goals are outlined which is especially helpful.

Wingate students are a pleasure to teach. They come prepared and are ready to learn. I have benefited greatly from being a preceptor. It helps me be a better pharmacist, helps refresh my drug and law knowledge, and gives me the opportunity to teach. If you want to be an effective preceptor, it will take some work. In order to make sure your students are learning, you must go the extra mile to make a difference in their lives. It is important to provide a friendly environment, lay out your expectations and goals, and take the time to teach each student. It is a fulfilling role that makes a big difference in a student's life.

- Joy Greene, PharmD
Pharmacist Manager
Oakboro Pharmacy
Oakboro, NC

For Best Results "Shadow" Your Preceptor, be Enthusiastic

I believe that experiential training is just as important as knowledge gained in the classroom, regardless of the profession. Pharmacy is no exception! Early practice experience affords pharmacy students the opportunity to interact with patients one-on-one, to learn from experienced pharmacists and support personnel, and to develop interpersonal skills. This type of learning cannot be simply taught in a classroom. Since experiential training begins on day one, students at Wingate University have the advantage of building upon relationships and improving necessary skills throughout the semester. This type of training is crucial for students who enter pharmacy school with little to no practical experience.

We were required to train at our practice site roughly eight hours per week during the entire semester. In my opinion, the amount of time devoted to experiential training at Wingate University is sufficient to observe and participate in the daily operation of retail pharmacy. During this time, I learned how to counsel patients more effectively and confidently. In addition, I observed how pharmacists interact with patients and support staff alike. Most importantly, I participated as part of a team in providing healthcare to patients.

The primary benefit of having a pharmacist practitioner mentor is the chance to learn firsthand from someone who knows how to effectively deliver pharmaceutical care to patients. Practicing pharmacists have a wealth of knowledge that students can learn from if they only take the time to observe and listen! In addition, pharmacists are the best multi-taskers and experiential training helps students appreciate this concept!

I learned so much from the pharmacy technicians at my rotation site. They were always gracious and eager to answer my questions. Students should never take for granted the skill and knowledge of pharmacy technicians.

My advice to pharmacy students is to actually "shadow" your preceptor. Stand beside your preceptor as they speak with patients who have questions about their medication. Listen to the preceptor as well as support staff as they converse with patients and physicians on the telephone. An eager and enthusiastic attitude will help you get the most out of your experience and may possibly motivate others.

Finally, my advice to preceptors is to be you! I currently work with two pharmacists who are unaware that they are helping to mold my career as a knowledgeable, caring, and compassionate pharmacist simply by being themselves.

- Lauri Saleeby
PharmD Candidate, Class of 2007
Wingate University School of Pharmacy

If you are interested in becoming a preceptor please contact one of the following university programs:

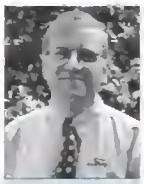
Campbell University
Valerie Britt Clinard, PharmD
Director of Experiential Programs
910.893.1716
clinardv@mailcenter.campbell.edu

UNC-Chapel Hill
Kim I. Leadon, M.Ed.
Director, Office of Experiential Education
919.966.3023
kim_leadon@unc.edu

Wingate University
Dan Brown, PharmD
Director of Early Practice Experience
704.233.8336
dbrown@wingate.edu

Patient Safety, Intimidation and Doing What's Right

Gene Kranz was the NASA controller whose words, "Failure is not an option," were immortalized in the movie *Apollo 13*.[1] Kranz also contributed to the rebound of NASA from the Apollo 1 tragedy. On Jan. 27, 1968, three astronauts (Gus Grissom, Ed White, and Roger Chafee) were killed while preparing Apollo 1 for its first flight. A spark due to faulty wiring caused the fire in a capsule filled with 100% oxygen.[1]



by Bob Cisneros

Shortly after the fire, Kranz addressed his co-workers. He admitted that there was too much rushing and too many minor problems that were ignored in the weeks and months before the tragedy. Kranz said he didn't know what the official investigation would reveal but, in his mind, *"we caused the tragedy...no one stood up and just said "STOP."*[1]

Can we look back at our careers and think of times we wished we had spoken up in critical situations? Dispensed a particular prescription we assumed was correct for fear of an unpleasant encounter with a prescriber? Let outside influences affect our judgment? A recent study suggests that for some pharmacists the answer to these questions is "yes."[2,3,4]

ISMP Intimidation Survey

The Institute for Safe Medication Practices (ISMP) recently conducted an intimidation survey.[2,3,4] The subjects were 2,095 healthcare providers (including 1,565 nurses and 354 pharmacists) who worked in the hospital setting. Results of the survey indicated that among *all* respondents, many felt they were subjected, during the previous year, to such intimidating behaviors as condescending language or voice intonation (88%), reluctance or refusal to have their questions or phone calls answered (79%), and strong verbal abuse (48%).[2,4]

Among *pharmacists* in the survey, sixty-three percent revealed that during the previous year they assumed at least one medication order was correct rather than have to communicate with a particular prescriber. Five percent of the pharmacists each assumed more than ten medication orders were correct rather than communicate concerns.[4]

Unfortunately, ten percent of pharmacists reported that they had been involved in an error in which intimidation played a role. In addition, the ISMP study found that sixty-one percent of pharmacists felt their organizations did not deal effectively with intimidating behaviors. Succumbing to intimidation, or the threat of it, has an impact on patient safety.[2,3,4]

Though the survey was limited to the hospital setting, the results should serve as a "wake up call" to all of us, regardless of the practice site. The consequences of not speaking up are serious. At the heart of dealing with this issue is the patient. When we step back for fear of confrontation, who are we really putting first: the patient or ourselves?

A pharmacy student in one of my classes wrote about intimidation several months ago stating "The best thing to do is to think of the people you are helping. When you think about yourself, you either become angry at the way others are treating you, and maybe become intimidating yourself, or you step back and avoid confrontation to shield yourself from embarrassment."[5]

Communication failure is one of the leading causes of harm to patients. Most significant adverse events (Sentinel Events) in hospitals were found to have their root cause in some type of communication breakdown.[6]

Is it the Message or the Messenger?

While angry reactions of prescribers or other professionals can create an intimidating environment and make communication difficult, sometimes it may be the manner of communicating that contributes to an unpleasant situation. *Communication Briefings* noted that "conversations go astray not because we want them to, but because we are unable to avoid projecting an adversarial attitude."[7(p. 1)] The "my view is the only view" attitude can significantly reduce communication effectiveness regardless of how right one of the individuals may be.

Whetten and Cameron[8] have described "supportive communication" as communication that can address a problem and yet can preserve the relationship between the two individuals communicating. When supportive communication goes awry, *defensiveness* or *disconfirmation* can occur. When one becomes *defensive*, self-preservation becomes paramount. The ability to listen is reduced as one thinks of ways to defend self. Reactions can include avoidance, anger or aggression.[8]

Discommunication occurs when "one of the communicating parties feels put down, ineffectual or insignificant because of the communication."[8(p. 219)] This could result in a pharmacist or other health professional becoming reluctant to pursue any future concerns.

Suggestions

Several recommendations can be helpful in communicating with other health professionals.[3, 8-9, 10] (The original references contain more in-depth information that will be very useful.)

1. Keep the patient first; it's about the patient, not you. Stay relaxed in the face of anger. Don't take an angry reaction personally.

2. Describe objectively the problem and your concerns. Don't be hesitant to communicate your concerns but be respectful. Establishing the fact that you are very concerned can help alert the other individual that indeed this may be a serious issue. Don't beat around the bush.

3. Present factual information; do your homework; have pertinent doses, weights, lab values, allergies, medication list and other key pieces of information at your fingertips. Have a possible solution or alternative ready to present. Develop a reputation as a "problem solver."

4. Collaborate! Avoid pointing fingers or establishing who is right or wrong; you may place an individual in a defensive position in which the only reaction will be one of "self-preservation" and nothing will be accomplished. Be aware of the tone you are conveying.

5. Really listen. Don't concentrate on what to say next and miss what the other person is saying. There may be important considerations you will hear that you had not thought about.

In addition, the ISMP has offered several organizational recommendations regarding intimidating behavior.[3] These include: **(1)** establish a set of unacceptable workplace behaviors and enforce a zero tolerance for such behaviors, **(2)** discuss openly workplace intimidation with staff, **(3)** provide education for the staff on proper communication skills and dealing with conflict, **(4)** establish a resolution process when conflict arises and **(5)** lead by example and reward those who display positive collaboration skills.

We must never be reluctant to speak up and voice our concerns. Our communication should be professional and supportive as we strive to ensure that the patient's welfare remains as our primary focus. *It's about the patient!*

About the Author...

Bob Cisneros, PhD, Assistant Professor, Pharmacy Practice Department, Campbell University School of Pharmacy. ***If you would like to share any thoughts or experiences regarding this topic, please submit them via e-mail to: cisnerasR@campbell.edu or via regular mail at PO Box 192, Buies Creek, NC 27506. Contributions will be compiled and presented in a future article in North Carolina Pharmacist. Names will remain confidential unless permission is given to use.***

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NORTH CAROLINA PHARMACIST RECOVERY NETWORK

PRN

Assisting Pharmacists with Substance Abuse Issues

Since it's incorporation as a non-profit in 1991, North Carolina Pharmacist Recovery Network has served over 200 pharmacists, pharmacy technicians, and students with health and workplace problems. Most of these problems are related to the abuse of drugs, including alcohol. Even before the formal creation of the present service organization, the need for assistance of this sort was apparent and was addressed by a group of volunteers.

The program, well known as "PRN," is nationally respected as one of the first and best of such organizations in the country. Few states have a funded program operated by a professional full-time staff. The North Carolina Board of Pharmacy was a leader in the funding of the program and today furnishes 60 percent of PRN's operating budgeted funds.

"All newcomers to PRN are in distress" said Executive Director Paul Peterson. "Most are fearful, many are very ill, some are downright paranoid. Many have diverted drugs, stolen from employers or broken the law in some fashion. They are filled with shame over their behavior which is in conflict with their own value system. Most addicts are good people with a bad problem. Often, the first question they ask is 'Will I ever practice pharmacy again?' The answer is always, 'Yes, you will if you wish to.' "

"I got in trouble because I didn't really know how to live and was always unhappy. My treatment and a new life in a program of recovery have taught me so much, and helped me find peace, joy and confidence so I can handle anything that life brings."

- PRN program participant

One of the keys to the success of PRN is ***anonymity***. Many pharmacists with various problems have become members of PRN by self-referral or by being referred by a colleague, family member or employer. Such pharmacists are not known to the Board of Pharmacy or to the public. This critical element of anonymity aids in attracting those in need of PRN's services. People in crisis are often fearful and anxious. The anonymity is enabled and protected by PRN's status as an entity created by an act of the NC State Legislature and by Internal Revenue Code Section 501c3 statutes making PRN a non-profit organization.

Approximately one-third of referrals to PRN come from the Board, another third are self-referred, and the balance come from employers, law enforcement, etc. About 70 percent of current PRN referrals relate to hydrocodone abuse. Other common drugs of abuse are other opioids, stimulants, benzodiazapines, alcohol and barbiturates. Other issues referred to PRN are behavioral, psychiatric, problems of aging, migraines and other chronic pain problems.

PRN refers clients to various evaluators and diagnosticians, and then to appropriate treatment providers. PRN contracts also provide for mandatory and ongoing random drug testing, when appropriate, as well as continuing therapy and support functions as needed.

The NC Board of Pharmacy is the strongest single supporter of PRN. Board members frequently express their respect for, and gratitude to, PRN and its staff. A substantial portion of problems coming before the Board are referred to PRN. The Board is compassionate and understanding in its policy of referring health problems (such as substance abuse or dependence) for treatment and rehabilitation rather than disciplinary action. The Board of Pharmacy has been a pioneer and continues as a nationally respected leader in this regard.

PRN also provides educational services to the profession such as continuing education conferences, pharmacy student placements, consulting with employers and, it serves as an information source for a multitude of callers.

Future growth for PRN is virtually certain due to a number of reasons, including the fact that substance abuse is a steadily growing problem in the world. Estimates indicate that up to 10 percent of people are affected.

"Ask any pharmacist today, and he/she will tell you that their work is stressful. Managed care, higher volumes, corporate employers, longer hours, less opportunity for counseling patients and truly practicing the profession, are some current issues. These stressors are unlikely to diminish in the near future of the profession," said Peterson.

Experts who treat medical professionals with substance abuse issues believe that 15 percent or more of physicians, pharmacists, etc. need, or will need, assistance. If you apply a conservative estimate of 10 percent to North Carolina's 10,000 licensed pharmacists, 1,000 are in need of help. PRN has served only one quarter of those pharmacists. In a recent year they enrolled 11 new participants. Last year 34 pharmacists were enrolled.

PRN will continue to see a dramatic increase in growth. Over 30 new cases in 2004 will likely become 40 in 2005, and perhaps 50 in the following year.

"We are presently at capacity, and over it at times. PRN will need a second case manager and a full-time staff support person within a year," said Peterson. "I enjoy my work in this field because of the joy and satisfaction in seeing people in crisis pull their lives back together. Some of those we've seen have lost jobs, marriages, money, houses, the respect of their families, and more. The miracle is that over 90 percent of PRN participants have recovered many of these losses, and are successfully fulfilling the terms of their PRN contracts, including abstinence. Many of them are truly in recovery from their illness," he said.

Peterson came to the organization in October 2003 after many years of service with a similar program. Another new face and voice at PRN is administrative assistant Joy Peters. ❖

You can contact PRN at 919.545.8800.

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Despite Vaccine Shortage, Pharmacy Students Succeed with Operation Immunization

by Lana Borno

"Don't Hesitate-Vaccinate!" That was the slogan students were spreading throughout the University of North Carolina at Chapel Hill School of Pharmacy in the fall of 2004. The Operation Immunization (OI) campaign was an immense accomplishment and great success due to the 31 enthusiastic and hardworking first, second, and third-year pharmacy students involved in the planning. Despite the devastating news of the vaccine shortage that significantly concerned the organizers of the project, OI was still carried out and made its mark in North Carolina.

OI is a campaign with a mission to increase the number of patients receiving immunizations and educate patients throughout North Carolina regarding vaccines and vaccine-preventable diseases. OI is an American Pharmacists Association (APhA) sponsored project in which pharmacy schools throughout the United States compete to create an influential school immunization campaign with the most impact in local communities. Chapel Hill's School of Pharmacy competes in this event on an annual basis, having a tremendous influence throughout the Chapel Hill area. This year, however, the students involved made a decision to expand the project in various ways and spread the campaign outside of the Chapel Hill area, making it a statewide effort.

Operation Immunization Coordinator Lana Borno fills a syringe for use by a pharmacist during an OI clinic.

The students were organized with one Chief Coordinator, two Publicity Committee Chairs, two Education Committee Chairs, 12 Publicity Committee members, and 14 Education Committee members. They collaborated for months to carry out the project and wanted not only to vaccinate more people than in prior years, but also educate more people regarding the importance of vaccinations.

The Publicity Committee did a great job. The campus newspaper and campus television station were among media covering the project. A feature article appeared in the student-run School of Pharmacy newsletter and in addition, the project was featured in an alumni magazine sent to thousands of UNC graduates.

The OI students lined up eight clinic dates in October and November of 2004. The targeted clinics were in Chapel Hill, various Raleigh locations and even Mount Pleasant, NC. OI took place at the UNC School of Pharmacy, several Kerr Drug Pharmacy Stores, Moose Pharmacy, and at the North Carolina State Fair with Medicap Pharmacy. The pharmacy student's efforts at networking with collaborating professional pharmacists were exceptional and formed lasting impressions. Moreover, they proved that as students they could impact many patients.

A total of 291 patients were immunized during the first three clinics and students were looking forward to the remaining five dates when the flu vaccine shortage was announced. This unfortunate news led to the cancellation of all remaining dates of the campaign, even after promotional materials had already been distributed and posted throughout the state. These cancellations truly disappointed the ambitious students and the helpful pharmacists involved in the project. Despite the vaccine shortage, the pharmacy students wanted to continue the campaign with a focus on educating patients across the state. This effort was just as important as the vaccinations themselves and will leave patients with vaccine awareness for years to come.

After the vaccine shortage was announced, the Education Committee began preparing pamphlets summarizing pertinent information concerning patient immunization. The pamphlets were distributed to 13 senior centers, nursing homes, and health departments across the state including Chapel Hill, Durham, Hickory and Taylorsville. The students also worked with 21 radio stations to air Public Service Announcements during the months of the campaign, reaching thousands of people. The education campaign also urged patients to get vaccinated for other important immunizations in addition to the flu vaccine. As part of the effort, the pharmacy students sold Friendly Immunization Reminder Postcards during the clinics that took place and at numerous locations on the UNC campus. These cards urged patients to remind their family members and friends to keep up to date with their immunizations.

OI was a project that was expanded tremendously this year. Although the goal of vaccinating more people was not reached due to the nationwide vaccine shortage, the importance of immunization was successfully promoted through the education focused campaign.

With OI, the UNC School of Pharmacy students were able to plan a successful campaign that left an impression on many pharmacists and, more importantly, on many patients throughout the state.❖

About the Author...

Lana Borno is a PharmD Candidate, Class of 2006, at UNC-Chapel Hill School of Pharmacy.

Small Doses

NC Pharmacists Awarded AACP Grants for Research

The American Association of Colleges of Pharmacy (AACP) has awarded grants to support the work of 16 first-time researchers on faculties at U.S. colleges and schools of pharmacy whose collective studies include determining which antibiotics can combat the deadliest of hospital-related bacterial infections, limiting the occurrence of diabetes in patients with metabolic syndrome, improving drug delivery to combat cancer cells, determining the effectiveness of an antibiotic to combat bacterial infection in newborns, and the effectiveness of pharmacy curriculum on impacting critical thinking skills. Under the AACP New Investigators Program (NIP), first-time researchers can apply for a start-up grant of up to $10,000 for their research in the areas of biological sciences, chemistry, pharmaceutics, pharmacy practice and social and administrative sciences. The NIP awards are funded by a $150,000 grant from the American Foundation for Pharmaceutical Education (AFPE) as part of its mission to support the education of pharmaceutical scientists and to strengthen pharmacy education.

Award recepient Robert Cisneros, Jr., PhD, assistant professor of pharmacy practice at Campbell University, will use the grant to study the impact of the pharmacy curriculum on critical thinking and self-directed learning.

"Critical thinking and self-directed learning are essential skills for pharmacists because of the vast number of new drugs in use and the evolution of pharmacy into a more patient-centered rather than product-centered profession," said Cisneros.

"It is crucial that pharmacists be able to think critically and be life-long learners."

Richard A. Hansen, PhD, University of North Carolina at Chapel Hill School of Pharmacy, received a grant for "Predicting the Switch: Pharmaceutical Promotion, Insurance, and Treatment Costs."

Watts Addresses Campbell School of Pharmacy

Mickey Watts, President of the Pharmacy Network Foundation, delivered the 2004 Convocation Address to the Campbell University School of Pharmacy. He emphasized that students should find harmony and happiness in their work. He also stressed the importance of a positive attitude and encouraged students to be active in their state pharmacy association.

"Each and every one of us are accountable for all of our actions, our thoughts, the words we speak and the messages we send out to each other. Therefore, please send kindness, understanding, compassion and love to everyone you meet, and especially the patients you serve. This kindness and compassion will return to you ten-fold and your life and your professional endeavors will truly be filled with peace, love, joy, happiness and prosperity," he said.

UNC Wins Competition For Third Straight Year

UNC Pharmacy students April Miller and Amanda Ball, winners of the ASHP Clinical Skills competition.

For the third year in a row, students from the UNC School of Pharmacy won the clinical skills competition at the midyear meeting of the American Society of Health-System Pharmacists.

Amanda Ball, a fourth-year pharmacy student from Greensboro, and April Miller, a fourth-year pharmacy student from New Bern, came out on top in the two-day competition, which featured a record 85 two-person teams representing pharmacy schools from across the country. Associate professor Dennis Williams coached Carolina's team.

The competition challenges students to analyze a complex clinical case, pinpoint the patient's drug therapy problems, identify treatment goals, and develop a pharmacist's care plan.

This year's case involved a hypothetical patient with a weak heart who had suffered a heart attack in a hospital with limited facilities. Many complications, including very low blood pressure resulting from shock and the lack of surgical alternatives, added to the challenge of recommending an appropriate drug therapy for the patient.

The teams were pared to 10 finalists who appeared before a three-judge panel to defend the reasoning behind their decisions.

Ball and Miller each took home a trophy and $500. The School of Pharmacy also gets to keep the traveling plaque it has held for the past two years.

2005 Calendar

Feb. 23: ***Pharmacy Day in the Legislature.*** Here's your opportunity to discuss important pharmacy issues with your state legislators in Raleigh. Pharmacy professionals and students will gather at the Legislative building on Pharmacy Day to meet one-on-one with their representatives. The day's activities include health-awareness screenings and participants may also attend a special program to learn more about current political issues. An evening reception at the NC Museum of History will offer pharmacists an additional chance that day to speak with Legislators. Visit the NCAP Web site or call NCAP for more information.

March 7-9: ***NCAP Acute Care Practice Forum Meeting.*** Sheraton Imperial, Research Triangle Park, NC. Quality CE, outstanding speakers, networking opportunities and more will be offered at this year's meeting. Visit the NCAP Web site or call NCAP for more information.

April 1-5: ***APhA Annual Meeting.*** Orlando, FL. For more information visit www.aphanet.org

April 10-13: ***ACCP Spring Practice and Research Forum.*** Myrtle Beach, SC. For more information visit www.accp.com

April 21-22: ***Carolina Regional Conference.*** NCASCP meeting, University Hilton, Charlotte, NC.

May 1-3: ***NCPA Nat'l Legislative & Public Affairs Conf.*** Washington, DC. For more information visit www.ncpanet.org

May 16-18: ***ASCP Midyear Meeting.*** Orlando, FL. For more information visit www.ascp.com

June 11-15: ***ASHP Annual Meeting.*** Boston, MA. For more information visit www.ashp.org

Sept. 10-11: ***North Carolina Pharmacy Practice Seminar.*** Wilmington Riverside Hilton, Wilmington, NC. More information to follow.

Oct. 15-19: ***NCPA Annual Convention.*** Fort Lauderdale, FL. For more information visit www.ncpanet.org

Oct. 16-18: ***NCAP Annual Convention.*** Sheraton Imperial, Research Triangle Park, NC. There's something for everyone at North Carolina's largest pharmacy convention. More information will be available soon.

Oct. 23-26: ***ACCP Annual Meeting.*** San Francisco, CA. More information at www.accp.com

Nov. 9-12: ***ASCP Annual Meeting.*** Boston, MA. For more information visit www.ascp.com

Dec. 4-8: ***ASHP Midyear Clinical Meeting.*** Las Vegas, NV. More information can be found at www.ashp.org

In Memory of Vivian Smith

Vivian S. Smith (Mrs. William Julius Smith), age 91, of Stone Mountain, GA, died December 5, 2004. Vivian served on the staff of the North Carolina Pharmaceutical Association for over thirty years, assisting her husband, W.J. Smith, who served as Executive Director. Vivian was the coordinator of the NCPhA Woman's Auxiliary from 1940 to 1978. She and her husband were awarded Certificates of Membership in the NC Pharmacy Hall of Fame in 1978. Vivian was educated at the Ashland, Kentucky public schools, Berea College, and the Brookover School of Music. She was a member of the St. Andrews Presbyterian Church for eight years and was preceded in death by her husband, W.J. Smith. Surviving are her son, W. Allen Smith and daughter-in-law Klara Smith of Tucker, GA, granddaughters, Vicky Smith and Mrs. John (Wendy Smith) Player of Roswell, GA, and great grandsons, William Donald Player and Jeffrey Allen Player. Funeral services were held December 9 at St. Andrews Presbyterian Church in Tucker, GA. Memorial contributions may be made the Pharmacy Foundation: Smith Scholarship Fund, c/o UNC School of Pharmacy, Beard, Hall, CB-7296, Chapel Hill, NC 27599-7296, or to the Major Repair Fund at St. Andrews church in Tucker, GA.

Special Continuing Education Supplement

In order to better serve our members, NCAP will mail a special CE Supplement only to members who request it. If you would like to be added to the mailing list for CE contact Teressa Reavis at teressa@ncpharmacists.org or call 919.967.2237 ext. 22.

Campbell University ASCP Chapter Being Recreated

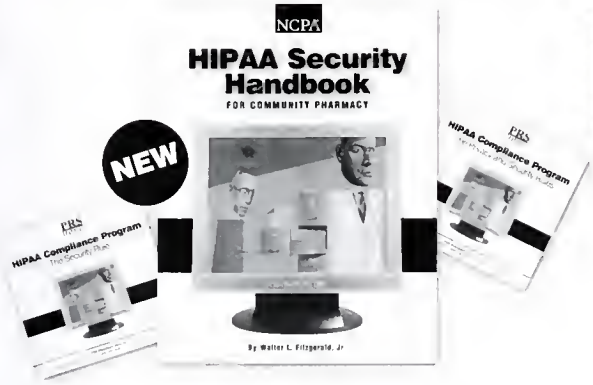
The ASCP chapter at Campbell University School of Pharmacy has had an exciting rebirth. They are in their second year of being recreated and already have many accomplishments to their credit. They used the fall semester to concentrate on membership and to date, the chapter has 18 members.

Officers were elected in October and are as follows: Rebekah Mooney, President; Carole Courcoux, Vice President; Tatjana Grgic, Secretary; and Wade Brown, Treasurer.

Six members attended the Annual ASCP Meeting in San Francisco in November. This was a great opportunity for the students to meet other state members of ASCP as well as members nationwide. Plans for the spring semester include community service at local nursing homes, hosting a guest speaker, and shadowing opportunities with consultant pharmacists. The student members of ASCP would like to thank the state chapter and Neil Medical Group for there valued support.

Some members of the Campbell University ASCP Chapter include: front (l to r) Otowve Eduvie, Rebekah Mooney, Carole Courcoux, Kong Yang, Wade Brown. Back (l to r): Meagan Wright, Kelly Talent, Tajana Grgic, Monika Medlik, Pascale Sleiman.

HIPAA security rule **deadline**



April 20, 2005, the Security Rule portion of HIPAA becomes law. Unlike the Privacy Rule, which became enforceable April 14, 2003, the Security Rule takes place behind the scenes and regulates your pharmacy operations, computer systems, and electronic information. The Security Rule is predicted to require more time to implement than the Privacy Rule, so don't delay. A Risk Analysis and a Disaster Recovery Plan are mandated under the Security Rule—**Are you ready?**

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2004 Building Remodeling Fund Contributors

The Institute of Pharmacy, which houses NCAP, is currently undergoing renovations thanks to the following individuals who contributed to the 2004 Building Remodeling Fund. Working together, we met the $50,000 challenge grant for 2004 and received a $50,000 match from the Pharmacy Network Foundation. A special thanks goes to Jack Watts who chaired the campaign. We have received another challenge for 2005 and contributions for this phase of the campaign are already coming in. If you would like to contribute, please make your check payable to the NCAP Endowment Fund and mail to NCAP, 109 Church Street, Chapel Hill, NC 27516 or contact Linda Goswick at NCAP: 919.967.2237, 800.852.7343, linda@ncpharmacists.org. Your contribution is tax-deductible. When the renovation process is complete we hope that you will visit *your* Association's office.

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We would like to express our appreciation to the following members and friends who contributed to the 2004 President's Club. Contributions received with 2005 membership renewals or at any time during 2005 will be recognized on the 2005 President's Club list.

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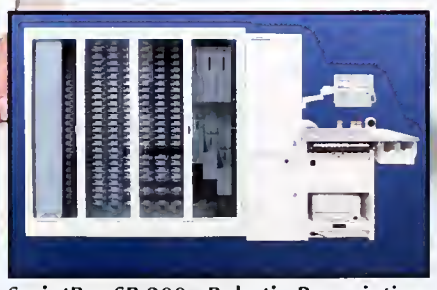

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North Carolina Pharmacist

Volume 85, Number 2 ...applying drug knowledge to improve health Spring, 2005

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North Carolina Pharmacist

Volume 85, Number 2 ...applying drug knowledge to improve health Spring, 2005

Inside

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Fred Eckel

A Message From the Executive Director

After reading the following commentary in Alabama Pharmacy, *I felt a need to share this message with North Carolina pharmacists. Recently I was told that how well pharmacists step up to the plate to offer Medication Therapy Management Services (MTMS) will be used by CMS to determine how they will revise the MTMS regulations, whether they will support pharmacists as providers under Part B of Medicare, and how many resources will be put into MTMS in the future. If we approach MTMS the same way we approached OBRA 90 counseling requirements we may be in trouble professionally. I hope you will not just read the commentary but reflect on it and then decide if your professional behavior needs to change. Our professional future is in each pharmacist's hands. The Medicare Modernization Act has empowered pharmacists to make a difference in the lives of older Americans. Will you step up to the plate, take advantage of the opportunity given you, and do what is best for your patient? I hope you will.*

Fred Eckel, RPh
Executive Director

Moral and Ethical Courage

by Bruce A. Berger, PhD
Professor and Head
Pharmacy Care Systems
Auburn University, AL

The Medicare Modernization Act offers exciting opportunities to pharmacists who can demonstrate improved patient outcomes, particularly in the area of chronic care improvement. We have the opportunity to achieve full fledged provider status and be compensated for it. Will we take advantage of this?

Several months ago I went into a pharmacy to get a new prescription filled. My prescription was filled and the pharmacist held out a clipboard with a pad of two-column, lined paper on it, pointed to the right-hand column of the pad and said, "Sign here." I looked through the pages of previous signatures and noticed that all signatures were in the right-hand column, which was labeled in small print, "I do not want counseling." The other column stated, "I want counseling." I was never asked whether I wanted counseling or if I had any questions before I was instructed to "Sign here." I did not receive verbal counseling. I looked at the pharmacist and said, "What you are doing is immoral and unethical."

"It's not my fault," he said.

"Who's fault is it?" I asked.

He said, "My boss wants us to do this."

What is wrong with this picture? Unfortunately, this is not an isolated event. I don't know if this pharmacist's boss really told him to do this. It really doesn't matter. What matters is this pharmacist was willing to put patients at risk....willing to violate his Code of Ethics that begins with a covenantal relationship between pharmacists and patients. How did we get to this point? This is especially distressing since there is supposedly a severe shortage of pharmacists. Being in short supply would allow pharmacists to demand more of what they want professionally. What happened to this pharmacist's sense of ethical obligation to the patient? If his boss did impose this standard, where was this pharmacist's moral courage to say no? I wish I could say that this is an isolated case. This is a national problem in the profession. Why do we put up with it? Do we not see how it hurts our ability to be compensated for the provision of services? Do we not see how it puts patients at risk? Do we not think it is our professional obligation to stop this and stop others from doing this? I realize that time is often short in community practice. I realize that compensation is not where it needs to be. However, we can't get where we want to go by putting patients at risk through tricking them into signing a waiver of their right to informed consent. Nor can we become the profession truly responsible for preventing and solving drug-related problems by asking a patient, "Do you have any questions" as if the patient would really know what to ask. This won't provide the outcomes we need.

What are we afraid of? What do we think will happen if we refuse to use these tactics and instead, simply counsel the patient? Do we think we will be fired for raising or upholding standards? We are in short supply. Is someone really crazy enough to fire a pharmacist for upholding the law?

Asking a patient to sign a waiver *must* stop, and I implore all pharmacists and pharmacy organizations to lead the charge. We simply cannot be a profession whose mission is pharmaceutical care and whose code of ethics states, "A pharmacist respects the covenantal relationship between the patient and the pharmacist," and "A pharmacist respects the autonomy and dignity of each patient" and then despite these promises to the public, we deceive patients into giving up their rights to informed consent.

When we do, covenants become shallow, useless contracts, and autonomy and dignity are simply words that we really have no intention of upholding. There can be no dignity when there is deception and no autonomy when the patient is uninformed.

I urge pharmacists to take a stand on this issue. This is a critical time in the development of our profession. We have an important window of opportunity with Medicare. We, as a profession, have been empowered by society to protect the public's health through the *appropriate* use of pharmacotherapy. This is our covenant. It is our gift; our promise to patients.

We have so much to offer the public. We ARE the drug experts. No other health professional has been trained to know as much about drug therapy and its appropriate use. The impact of pharmacists on total health care costs is well-documented. The Asheville Project is a shining example of what pharmacists can do to improve outcomes and lower costs. Hopefully, the PEEHIP project in this state will be another example of the benefits of pharmaceutical care. Let's find every way we can to help patients rather than avoid these responsibilities! The choice is ours. ❖

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North Carolina Association of Pharmacists
109 Church Street
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Davie Waggett

Dear NCAP Members,

One of the challenges in our lives, that occurs on a daily basis, is to decide whether or not we should get involved in a certain issue. Many times we ignore the issue and it goes away. I guess that can be described as having made a good decision to do nothing. At the same time, if we chose to ignore an issue, it may get worse or develop into some type of bigger issue that may mushroom into multiple problems. The opposite of this is when someone always takes immediate control of a situation, blows it out of proportion and then too much time is spent needlessly. However, there are times when people NEED to get involved, and they do step up to the plate, and great things are accomplished. Our great country, the USA, was built by those people who saw a very real need to get involved and to give of themselves.

So where is Waggett going with all of this? I love the profession of Pharmacy, and I hope you felt the passion that I have for Pharmacy in my last letter. Some very positive changes are being made in Pharmacy practice, primarily because some innovative people have decided to get involved to make these changes. At the same time, some negative changes are being made by those who do not have Pharmacy's best interest in mind, and they have managed to get by with it by using the political process against us. **Yeah, I am talking about getting involved with the political process** before your profession is legislated into something you don't want or don't recognize. Now before anyone reading this begins to yawn, I will try to tie it all together so that at the end of this letter you will see how all pharmacists will be affected, and how each one of you has a role in this issue.

Back in the days (and I will not say the "old" days), Pharmacy patient care was simple, yet effective. Patients went to the doctor, were treated, and needed prescriptions were ordered. Patients came to the pharmacy, had their prescriptions filled, and were educated about their medicines and their medical conditions. Time was taken by community pharmacists to talk with their patients and this is the basis for which pharmacy was voted "MOST TRUSTED PROFESSION" for so many years. This process was simple, yet very effective, and could be flourishing greatly with the new ideas and changes that have evolved in the last few years. Please note that I did not use any terms such as PBM's, insurance claims, equal access, any willing provider, insurance claim audits, rebates, out of network, sub networks, reduced dispensing fees, reduced MAC's, Medicare Part D coverage, 2006 Medicare RX drug plan, etc. All of these terms have absolutely nothing to do with the practice of Pharmacy but as pharmacists, we are forced to deal with these terms and entities every day. Almost every one of these terms works AGAINST the Pharmacy profession, and for the most part, we as the profession of Pharmacy do very little about the impending dismantling that is going on. Most of these issues are handled, or dealt with, on a political basis, and most of it goes on in Raleigh, North Carolina (except for the Medicare issues). We must begin to become VERY aware of what our politicians are doing and allowing in Raleigh. A few (but growing number) of legislators are working on our behalf, but a larger number are working against what we have been providing to our patients for many years. We must, as a united profession of Pharmacy, band together on the many important issues that are facing us today and let our politicians know how we feel. We can no longer rely solely on the relatively small handful of active pharmacists that are fighting for all of Pharmacy, no matter what area of practice you are in. We must help. We must get involved either with our time, our money, our efforts, or all three. We must become more comfortable with picking up the phone and calling our representatives. It is not difficult at all, but it takes time.

What are the some of the possibilities if we do not get involved? I believe that most people just don't get involved until it hurts them financially, or an issue develops into something that prevents them from practicing their profession as they see it should be practiced. Well, these two areas are very distinct possibilities for the near future, if we don't do something about them. If your employer decided to knock off $15.00 or $20.00 **per hour** (just an example) of your salary, would that get your attention? This idea could trickle into every area of Pharmacy practice. What if pharmacists who only did dispensing functions were getting paid half of what pharmacists made who were doing MTM (medication therapy management). Would that be enough to get pharmacists involved with the political process? I would hope so. These two examples are just that, examples. But I have to tell you, I am not the first one to think these concepts up. Are you listening?

I am not a pessimist at all, but I do try to be realistic in my views and thinking. Could these things happen? Maybe or maybe not. Are we as a profession ready to "step up to the plate?" I sure hope so... Love your profession and take care of your profession. It's the right thing to do.

Davie Waggett, RPh
President

...applying drug knowledge to improve health

Web Site Updated to Improve Member Communication

Members have been asking for a more interactive Web site so now it's here- a better way to communicate. Our new site has state-of-the-art features designed to improve member communication, make navigation easier and help you find information fast through our on-site search engine. You'll find our main menu on the top navigation bar, new and updated areas on the left navigation bar, and the latest news, meeting announcements, etc. on the right. A new survey feature will allow us to get feedback from members almost instantly. We've added special sections for Sponsors, the Endowment Fund, Immunizations and more. Employers can post job opportunities and members can post resumes and search for employment in our Career Center (formerly NCAP Web Classifieds). Our secure site gives members the option to register online for meetings, renew memberships, and purchase merchandise in our Member Mall. Every time you make a purchase from one of our merchants NCAP receives a portion of the profit so please, do your online shopping through the NCAP Web site. The new NCAP Web site will save the Association money and time and keep you up-to-date on issues that affect pharmacy. Browse around and let us know what you think.

More of what you want: www.ncpharmacists.org

It's Not Just "The Asheville Project" Anymore

The Asheville Project continues to grow and there are now 15 other communities across the country that have started similar pharmacist-driven disease management programs.

The March/April 2005 issue of the Journal of the American Pharmacist Association published first-year outcome results on five of these sites. This particular initiative is being piloted and coordinated by the APhA Foundation. Their results, on 256 patients with diabetes, are amazingly similar to the first-year results in Asheville. It is encouraging to hear that this approach is working in other communities and is not just something unique to Asheville.

Currently in Asheville there are 973 individuals enrolled in our employer-sponsored, pharmacist-run, disease management programs. Four employers in the area offer this program to their employees and these employers have a total of about 15,000 covered lives in their health plans. So, about 7% of employees are participating in this pharmacist-driven disease management program. One measure of the success of the program is that the employers have added the program as a permanent part of their health plans, along with their normal medical, dental, and prescription benefits. The program is entering its ninth year and the plan is to continue to follow these patients indefinitely. This will result in a long-term outcome study that will be unique not only for pharmacy, but for the whole field of disease management.

We currently offer programs for diabetes, asthma, hypertension and hyperlipidemia. There are 239 people with asthma, 387 with diabetes, and 627 with hypertension and/or hyperlipidemia. Two hundred sixty nine (28%) have more than one of these conditions and over 60% of patients with diabetes also have hypertension and/or hyperlipidemia. Obviously pharmacists are dealing with multiple disease states in many cases and we believe this is a distinct advantage to using pharmacists as care mangers in disease management programs. Pharmacists have a broad spectrum of health care knowledge and are capable of dealing with multiple disease state issues.

As many of you are aware, in this program the employers agree to pay pharmacists for their counseling/coaching time and the patient and pharmacist meet face-to-face on a regular basis for one-on-one counseling. In our experience this averages about once every other month, for 30 minutes. In addition to meeting with the pharmacist long-term, the participating employee also agrees to go through disease specific education classes provided at the Health Education Center at Mission Hospitals. As long as patients continue to participate they qualify for significantly reduced, in most cases zero, medication co-payments on the medications related to their illness. The reduced co-payments not only encourage enrollment initially, but the threat of losing this benefit also helps keep people engaged. It is important to point out that this carrot-stick approach addresses two significant problems that plague more traditional disease management approaches. Programs sponsored by some health plans (e.g. BCBS, Cigna, United Healthcare) are frequently just nurse-driven telephonic programs. They have great difficulty enrolling patients and keeping them engaged and participative. They tend to have minimal impact on patients' health because they are limited to patient education efforts and do not establish long-term relationships with many patients. They also tend to focus primarily on employees who have been costing the health plan a lot of money (i.e. they had a bad year) rather than on all individuals with the condition. By doing this they miss a lot of people with significant needs who, although they are not doing well, have yet to crash and burn and hit the financial radar screen.

Charlene Williams (left) is a provider in the Asheville Project.

We will soon be submitting a study for publication on six years of asthma program results on 207 patients. We have found significant improvements in FEV1 (Forced Expiratory Volume in 1 second), decrease in asthma severity scores, decrease in objective asthma symptoms, improvement in quality of life, increase in numbers of patients with asthma action plans, and decreases in emergency room visits and hospitalizations. The number of people experiencing night time symptoms two or more times a week, or asthma flares/attacks two or more times a week, were cut by more than half, and 70% of patients had improvements in objective parameters. The economic data is currently being summarized and will be compared with patient's historical costs and a control comparison group.

Clearly this simple pharmaceutical care model can be effective for chronic conditions other than diabetes, and it is replicable in other communities. It's not just "The Asheville Project" anymore.

About the Author...

Barry Bunting, Pharm D, is the Clinical Manager of the Pharmacy Department and Asheville Project Coordinator at Mission Hospitals in Asheville, NC.

Pilot Study Report

Medication Therapy Management Service for North Carolina State Employees Health Plan Members in Durham and Orange Counties

Introduction:

Medical literature has documented the growing complexity of medication use, and the increasing likelihood of adverse patient outcomes. Drug-related problems pose a health threat to patients and additionally have a significant fiscal impact to the health care system. Costs associated with drug therapy problems have more than doubled over the past five years to an estimated average of $177 billion, with nearly $80 billion of this in the ambulatory setting. It is estimated that for every $1.00 spent on a medication, $1.34 is spent on treating or resolving a drug therapy problem.[1, 2] While these are only estimates, the magnitude of drug usage and the apparent drug "problem" seems clear. The Institute of Medicine (IOM) in their report "To Err is Human" states: "it is impossible for nurses and doctors to keep up with all of the information required for safe and effective medication use. The pharmacist has become an essential resource…and thus access to his or her expertise must be possible at all times." [3] Here in North Carolina, the North Carolina State Employees Health Plan (SEHP) is acutely aware of the growing difficulties in managing a drug benefit in an era of ever-increasing drug prices, as well as the health and cost consequences for these patients.

The service:

In May of 2004, a group of pharmacists (including the authors) proposed to the SEHP that a polypharmacy review service be developed to address the drug-related needs of patients using high numbers of prescriptions. The program would consist of an invitation to patients to schedule a visit with a designated pharmacist near their home who would conduct a "brown bag" type review of their medications, interact with prescribers as needed to address changes in drug therapy, and communicate these changes to the patient at a follow-up meeting. It was expected that the service would render drug therapy for patients that were more rational and simple, but would also lower total drug costs. An added indirect benefit would hopefully be potentially lower costs of medical services used, particularly for visits occurring as a consequence of inappropriate drug therapy combinations.

The meeting was a success. Authorization was given to launch a pilot demonstration project targeting members in Durham and Orange counties beginning in August of 2004 and running through March 2005.

As part of the intervention, the SEHP used dispensed prescription records to identify patients at high risk or for sub-optimal drug therapy or drug-related problems who would be eligible for a comprehensive drug profile review and assessment. These patients received a letter of invitation from the SEHP that explained the program and offered them a "free" brown bag drug regimen review consultation. The letter noted that there would be no out-of-pocket cost for this service and that it was designed to improve control of their health conditions on their current medications and possibly lower their medication costs. Only the first 100 patients responding to this invitation would be eligible for this pilot program. The SEHP linked a responding patient with a participating pharmacist located in either Orange or Durham County who had prior experience in providing this type of pharmaceutical care service, practiced in a nearby pharmacy setting that assured privacy and completed a training program specific to the SEHP project. The project included 12 pharmacists from a variety of retail settings.

Pharmacists were expected to set up an appointment with the patient and perform an initial assessment that included history, discussion of meds, progress toward a treatment goal, compliance, side effects, patient self-management education and monitoring device training, if applicable. Follow-up responsibilities of the pharmacist were to identify possible drug-related problems along with opportunities to achieve more cost-effective care from the patient's perspective (i.e., lower co-payments) as well as the SEHP perspective. The pharmacist was then expected to contact the prescriber to discuss the patient's drug regimen, and to communicate this change to them and to his/her pharmacy of choice. All interventions were thoroughly documented. Pharmacists were compensated for one initial and one follow-up visit with the patient.

Present status:

The service portion of the pilot project has ended with approximately 85 patients participating as of the pilot study end date. As part of the project design, Dale Christensen and colleagues at the UNC School of Pharmacy will evaluate the results of the pilot project. The focus of the evaluation will be on assessing: 1) the results of pharmacist reviews, in terms of the number and type of drug therapy changes made, 2) the drug cost impact of any drug therapy changes, and 3) patient satisfaction with services provided. The results will be compared to a control group chosen with similar profiles from Wake County. We will also be examining impact on total medical care use and costs, however, we do not anticipate much impact due to small sample sizes and the short time period involved.

Final thoughts:

We believe this program has great potential for pharmacists in North Carolina. Although not restricted to the elderly, it shares many of the same features of the Medication Therapy Management provisions under the 2003 Medicare Modernization Act, due to begin in January 2006. Compared to similar ambulatory polypharmacy intervention programs, we believe that an especially important feature of this program is the fact that patients were offered the service as an extra plan benefit. Expansion of this pilot program to more patients in these target counties or in other NC counties will await evaluation results. We anticipate completing the evaluation by October 2005. ❖

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About the Authors...

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NCAP-NCASCP Merger Sealed at Historic Meeting in Charlotte

NCAP Welcomes the North Carolina Chapter of the American Society of Consultant Pharmacists

Cecil Davis, (second from right) with representatives from Boehringer Ingelheim who sponsored a breakfast during the meeting.

Attendees at the Carolina Regional Conference browse the exhibit hall and interact with vendors.

by Cecil Davis, PharmD, CGP

On April 21 and 22, the Carolina Regional Conference was held in Charlotte, North Carolina and many thanks go out to MEDS, Margaret Sgritta, Lori Edwards and Dale Jones for an excellent meeting with informative speakers. We were honored to have Diane Crutchfield, the current ASCP president, as part of our meeting.

On Friday morning, April 22nd, the North Carolina Chapter of the American Society of Consultant Pharmacists met for the last time. The Chapter voted prior to the meeting to dissolve its charter and devote its energy and talent to the Chronic Care Practice Forum (CCPF) under the North Carolina Association of Pharmacists. Rick Whitesell, the CCPF Chair, stressed the importance of maintaining close ties with ASCP.

"Due to the changes in the coming year our relationship with ASCP is more important than ever," said Whitesell. The CCPF will enter into an affiliate relationship with ASCP as allowed by their bylaws. The spring long-term care educational meeting will continue and committee chairs will continue in their current roles.

We should never forget the vision that our fellow pharmacists exhibited in forming the North Carolina Chapter of ASCP. As we move forward, we must not forget the hard work it has taken to build the Chapter. This new Chronic Care Practice Forum needs to be built in a way that serves the needs of senior care and long-term care pharmacists in all practice areas. If you have ever thought about being a part of CCPF now is the time. The procedures that are put in place over the next few months will be precedent setting and serve the Forum for years to come. The excitement and cooperative attitudes that are brought into the Forum will determine its success. As Winston Churchill said, "This is not the end, or even the beginning of the end. It is perhaps the end of the beginning."

The first meeting of the CCPF will be May 24 at Holladay Healthcare in Winston-Salem. This will be a groundbreaking meeting as we determine the course for the CCPF for the next several months. Please attend! The future of CCPF is bright and we hope you will be active in its future.

For more information about the May 24 meeting contact NCAP or visit www.ncharmacists.org.

NCAP would like to extend a warm welcome to members of the NCASCP.

THE NCAP CHRONIC CARE PRACTICE FORUM ENCOURAGES MEMBERSHIP IN ASCP: www.ascp.com

Pharmacists, State Legislators Come Together at Pharmacy Day

Pharmacy Day in the Legislature brought together pharmacists and state Legislators on February 23 in Raleigh. Participating pharmacists and students used the opportunity to discuss important pharmacy issues with their Legislators.

The day began with a Health Fair in the Legislative Building. Pharmacists and students from Campbell University and UNC-Chapel Hill were on site to address medication-related questions and provide one-on-one health awareness screenings.

An afternoon program was held in the North Carolina Museum of History so participants could learn about current political issues and the basics of influencing elected officials prior to meeting with their Legislators. Later in the evening, pharmacists had the opportunity to meet with Legislators at a reception held in the lobby of the Museum.

Pharmacy Day was sponsored by the Association of Community Pharmacists, the Chain Drug Committee of the North Carolina Retail Merchants Association, the North Carolina Association of Pharmacists, and the North Carolina Chapter of American Society of Consultant Pharmacists.

Pharmacists and pharmacy students held a Health Fair in the Legislative Building during Pharmacy Day and conducted health-awareness screenings.

North Carolina Association of Pharmacists
2005 Acute Care Practice Forum Meeting
March 7-9, 2005, Research Triangle Park, NC

Those who attended NCAP's 2005 Acute Care Practice Forum Meeting enjoyed three days of excellent continuing education. Besides receiving quality CE, attendees were able to network with colleagues, browse exhibits, attend receptions, a poster session, and more. The meeting was held at the Sheraton Imperial Hotel and Convention Center in Research Triangle Park, North Carolina.

Right: A UNC pharmacy student participates in the Tuesday evening Poster Presentations.
Below: Lunch time in the exhibit hall.

Above: Those in attendance enjoyed the food and exhibits at the Tuesday evening reception. Below Left: Exhibitor John Kessler with Second Story Health, speaks to an attendee. Below Right: Debbie Miller (l) presents the Acute Care Pharmacist of the Year Award to Jane Younts.

Using Sigma Strategy to Improve Medication Safety

by Bill Harris

Six Sigma philosophy and methodologies have been adopted in health care to utilize the analysis and statistical tools to improve the processes and systems in medication use. In the business and industry environment, the underlying Six Sigma concept is that perfection is possible. A comparable philosophy in medicine may be a combination of the concept of "first, do no harm" and belief that it is possible to achieve world-class quality through continuous improvement to meet our patient's needs and expectations.

In industry, Six Sigma is a measure of the deviation from the mean or average which represents the best quality produced that meets customer needs and expectations. Defects are represented graphically as outliers beyond the six standard deviations for the desired quality in products or services. In Six Sigma terms, the standard of excellence allows only 3.4 defects per million opportunities. At Six Sigma standards, the error rate for dispensing would be only 3.4 errors per million prescriptions processed. In the hospital, there would be only 3.4 drug administration errors per million doses administered. For example, deaths related to anesthesia during surgery have been reduced to an estimated 5 deaths per million cases, which equates to approximately 5.9 Sigma level. See the table below for other quality examples.

There are five phases in the Six Sigma approach to quality improvement— Define, Measure, Analyze, Improve and Control **(DMAIC model).** In the **Define phase,** a problem is identified that results in undesired outcomes and does not meet the expectations of the customer or the company. Projects are selected that have a business case to support that fixing the problem will result in financial gain, savings, or cost avoidance, as well as other benefits. A problem statement and mission statement are written to clearly describe the processes to improve, project goals, factors that are critical to quality, stakeholders, patients, customers, timeline for completion and potential savings and benefits. In a hospital for example, patients treated with insulin may experience adverse drug effects (ADEs) that are unintended, undesirable and cause patient harm, a costly problem. The problem statement should define how many insulin ADEs have occurred that resulted in patient harm, time period reviewed, location and background information. The mission statement defines the goals, how the improvements will be measured, how much improvement is expected and the projected savings. For example, insulin ADEs with adverse patient effects will be reduced by 50% within six months in the surgery care units, resulting in a $10,000 savings for each ADE avoided.

In the **Measure phase,** the data is collected and validated. Factors that affect the output are identified and reviewed for cause and effect. Results are used to revise or validate the problem and mission statements, baseline data and target performance. For example, the number, severity and types of insulin ADEs are verified and potential causes of the ADEs are identified. Use the data to confirm the volume of ADEs that need to be eliminated in order to meet the 50% reduction goal in six months.

The **Analyze phase** examines the data for key process variables that result in the unwanted outcomes (defects, failures or ADEs). A detailed process map should be prepared to identify process and system failures and all potential causes of variation. The goal is to identify all factors that affect the outcome, determine the relation-

Sigma Level	Defects per million opportunities	Health care examples	Industry & business examples
6	3.4		Allied-Signal(now Honeywell): 3 model factories
6			Publishing: one misspelled word in all the books in a small library (3.4 million words)
5.9	5	Deaths caused by anesthesia during surgery	
5	230		Airline fatalities
4	6,210		Airline baggage handling
4	6,210		Restaurant billing
3.8	10,000	1% of hospitalized patients injured by negligence	
3	66,800		Publishing: 7.6 misspelled words per page in a book
2.3	210,000	21% of ambulatory antibiotics used for colds	
1.3	580,000	58% of patients with depression not detected or treated adequately	
0.7	790,000	79% of eligible MI survivors fail to receive beta blockeers	

Adapted from Walmsley, Behara, Jackson and Chassin references.

ship between the factors and output and provide statistical analysis of the data to confirm areas for improvement. The FMEA process may be useful for difficult or complex problems. Using the insulin ADE example, the ADEs should be analyzed for medication use breakdowns, system failures, time relationships (month, day, shift and time), staffing variables, personnel factors (experience, education, performance, permanent staff, contract, etc.), equipment and environmental factors.

In the **Improve phase,** actions are identified that will correct the problems that have been confirmed. The goal is to optimize the operation, eliminate or reduce defects and variation in the output or outcomes. Actions may be tested in pilot or experimental steps to determine if positive results occur. Ideas and plans are implemented and outcomes are measured to determine if the target goal has been achieved. The relationships between cause and effect may be validated with statistical analysis and other methods to measure the outcomes. One approach to reduce insulin ADEs is to utilize the **Six Sigma mistake proofing process.**

The steps include elimination, replacement, facilitation, detection and mitigation. For insulin ADEs, **elimination steps** may include simplifying the therapy protocol, using the best insulin nomogram (not a different plan for each department or service), using preprinted order forms and implementing barriers to prevent failure (use CPOE to eliminate handwriting errors, use electronic MAR to eliminate transcription errors, reprint MARs after order sets are processed). **Replacement actions** may include using smart infusion pumps to avoid pump programming errors, standardize to one insulin drip concentration and select a better blood glucose device for more consistent BG measurement. **Facilitation steps** may include staff improvement in insulin knowledge, BG management and critical thinking skills. Other steps include the development of insulin champions in each nursing unit to educate new nurses, utilize communication tools to improve shift to shift reports, improve treatment algorithms for insulin and BG management, monitor staffing ratios and emphasize the six rights of medication use. **Detection steps** may include improvements in critical thinking skills, quick recognition of adverse effects and an algorithm for appropriate actions for management. **Mitigation steps** include increased knowledge and implementation of treatment and communication actions to treat adverse insulin effects before the patent experiences significant injury.

The **Control phase** of the DMAIC model identifies key factors to monitor to validate that improvement has occurred, and actions to maintain the improvement over time. Lessons learned and best practices are communicated to the care team and management. Goals include assigning personnel to monitor, document and communicate positive or negative results to the process owners for follow-up. For insulin ADEs, monitor the factors that failed previously to ensure that the changes implemented are effective to prevent failure and recurrence of insulin ADEs. Perform periodic accountability audits to validate the improvements. Be prepared to restart the DMAIC process to address evidence that the problem is not resolved.

Six Sigma success starts with senior management support and resources to solve the problem identified. Project champions are selected based on their concern and desire to solve the problem, their authority and ability to implement the improvements and their leadership abilities. The Six Sigma process utilizes experts (called Black Belts) trained in the use of Six Sigma tools and concepts. Black Belts facilitate and lead the project team, teach the Six Sigma methodology, report the progress and results to senior management and transfer the lessons learned to other areas of the organization.

The Six Sigma process is a robust method to solve difficult problems. Numerous Fortune 500 companies, such as General Electric, GM, Ford, 3M, Sony, Honeywell and DuPont have adopted this quality improvement process with impressive results. Statistical JMP software is available from SAS to analyze the data, to test hypotheses, to provide graphical analysis, to test process capability, to perform multi-variant, ANOVA, correlation and regression analysis, to perform design of experiment projects and to provide control charts for monitoring improvements.

The Institute of Medicine report stressed that health care must reduce the number of patient deaths and injuries related to medications. Will health care ever achieve the near perfection of Six Sigma in practice? Perhaps, the desire to improve from the current Sigma level to the highest level possible should be the goal. Finding solutions to adverse drug events requires an effective, systematic approach and sound methodology. Six Sigma tools and the DMAIC model provide the structure and statistical analysis to improve medication safety. Industry and business have shown that Six Sigma strategy makes good business sense. ✣

About the Author...

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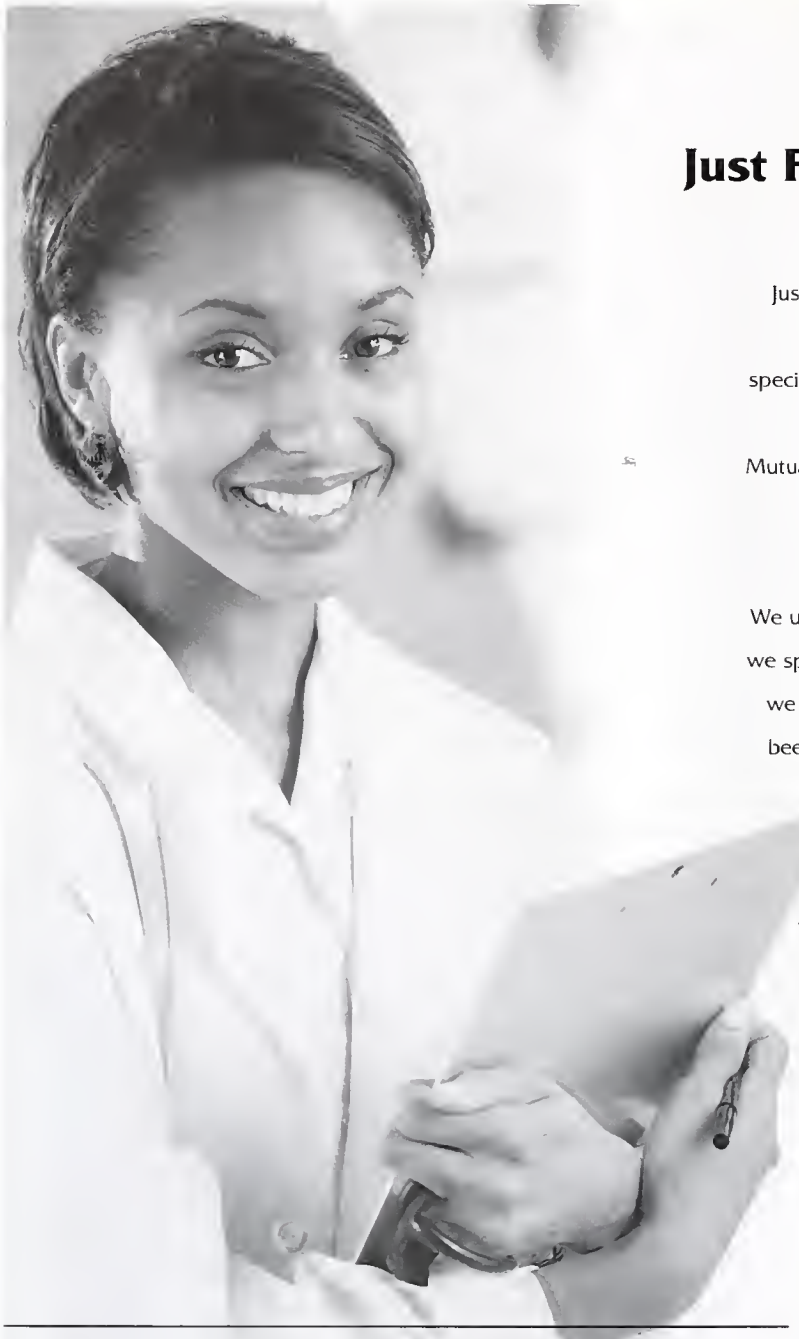

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Doors, Floors, Windows and More Undergoing Renovation at NCAP

Institute of Pharmacy renovations are in full swing and should be completed by this summer. The 2004 Building Remodeling Fund met a $50,000 challenge grant for 2004 and received a $50,000 match from the Pharmacy Network Foundation. NCAP has received another challenge for 2005 and contributions for this phase of the campaign are already coming in. You can make a tax-deductible contribution at www.ncpharmacists.org or send a check made payable to the NCAP Endowment Fund to NCAP, 109 Church Street, Chapel Hill, NC 27516.

Small Doses

UNC PHARMACY STUDENT WINS APhA AWARD

UNC pharmacy student Susan Herndon has been selected as a winner in the Pharmacy Student One to One Patient Counseling Recognition Award Program. She will receive the following: Airfare to Orlando for the 2005 APhA Annual Meeting, three nights' hotel accommodations, and full complimentary registration for the meeting. She will also be a guest of honor at the APhA 2005 Opening Reception.

PHARMACISTS MUTUAL HONORS RON STOLL

Ronald Stoll, LUTCF, North Carolina Field Representative, was presented the "Commitment to Excellence" award at Pharmacists Mutual's Annual Sales and Marketing Meeting held in January. Ron joined Pharmacists Mutual as a field representative in 1996. Ron and his wife Charlotte, who is employed as a long-term care consultant with Senior Care Concepts, reside in Summerfield, North Carolina.

KENNEDY RECEIVES HOPA AWARD OF EXCELLENCE

LeAnne Kennedy, PharmD, BCOP, has been selected to receive the first annual Hematology/Oncology Pharmacy Association (HOPA) Award of Excellence. The Award of Excellence recognizes a HOPA member who has made a significant contribution to or provided excellent leadership in developing or supporting hematology/oncology pharmacy by:
1) Providing or creating an innovative hematology/oncology pharmacy service
2) Providing or creating an innovative hematology/oncology pharmacy training program
3) Contributing to innovative research that promotes safe and cost-effective use of cancer-related treatments
4) Contributing to innovative basic hematology/oncology science research
5) Serving as a hematology/oncology pharmacy advocate
6) Serving as a hematology/oncology patient advocate or
7) Creating or promoting public awareness of the value of hematology/oncology pharmacy

Kennedy serves as Pharmaceutical Care Coordinator for Oncology at Wake Forest University Baptist Medical Center. She will receive the award on June 2, 2005 at the annual meeting of HOPA in San Diego, CA. HOPA is comprised of pharmacy clinicians, educators, and researchers who specialize in hematology and/or oncology.

UNC HOLDS SECOND ANNUAL WHITE COAT CEREMONY

In a ceremony held on Friday, April 8, third-year students received the traditional symbol of health professionals, the white coat, to mark their transition into the final year of the PharmD program.
"The White Coat Ceremony represents the student's dedication and commitment to the practice of pharmacy," said Dean Blouin. "Students in the class of 2006 organized the event to honor the professional standards they will uphold as they begin their fourth and final year of training at clinical sites across North Carolina."
The ceremony took place in the auditorium of the Medical Biomolecular Research

Building, and the keynote speaker was Carla White-Harris, clinical assistant professor. Following the ceremony, a reception was held in the lobby for students, faculty and guests. The White Coat Ceremony was sponsored by the North Carolina Association of Pharmacists.

SEEKING CANDIDATES FOR NCAP ELECTIONS

Deadline for nominations, June 30, 2005.

NCAP will elect a 2006 President-Elect (to serve as President in 2007, 3-year term), a Treasurer (three-year term) and one At-large Board member (3-year term). Members may submit nominations or requests to be considered for these positions. Send to NCAP Nominations Committee, 109 Church Street, Chapel Hill, NC 27516. FAX 919-968-9430 or email to linda@ncpharmacists.org.

Acute Care Practice Forum: The Practice Forum will elect a Chair-Elect (3-year term), two Executive Committee members (3-year terms) and one Delegate to ASHP (3-year term). Members of the Practice Forum may submit their nominations to Debbie Miller, Chair of the Acute Care Practice Forum. FAX 704-355-5206 or e-mail to dmiller3@carolina.rr.com.

Ambulatory Care Practice Forum: The Practice Forum will elect a Chair-Elect (3-year term) and one Executive Committee member (1-year term). Members of the Practice Forum may submit their nominations to Brenden O'Hara, Chair of the Ambulatory Care Practice Forum. FAX 919-968-9430 or e-mail to bpohara@nc.rr.com.

AWARD NOMINATIONS

Deadline for nominations, June 30, 2005

It is a privilege for the North Carolina Association of Pharmacists to recognize excellence within the profession. NCAP will hold its Awards Ceremony during the Convention October 16-18 in Research Triangle Park, NC. The Board of Directors invites NCAP members to make nominations for the following awards. Nominations must include biographical data on the nominee for review by the Awards Committee. Submit to Awards Committee, NCAP, 109 Church Street, Chapel Hill, NC 27516, Telephone 800-852-7343, FAX 919-968-9430 or e-mail linda@ncpharmacists.org.

Don Blanton Award: Presented to the pharmacist who has contributed most to the advancement of pharmacy in North Carolina during the past year. This award was established by Charles Blanton in memory of his father, Don Blanton, who served the North Carolina Pharmaceutical Association as President in 1957-58.

Elan Pharmaceuticals Innovative Pharmacy Practice Award: Presented to a pharmacist practicing in North Carolina who has demonstrated Innovative Pharmacy Practice resulting in improved patient care.

Pharmacists Mutual Distinguished Young Pharmacist Award: Criteria for this award are: (1) Entry degree in pharmacy received less than 10 years ago (1995 or later graduation date); (2) Licensed to practice pharmacy in NC; (3) Actively practices retail, institutional, managed care or consulting pharmacy; (4) Participates in national pharmacy associations, professional programs, state association activities and/or community service.

Wyeth Pharmaceuticals Bowl of Hygeia Award: Criteria for this award are: (1) Licensed to practice pharmacy in NC; (2) Has not previously received the Award; (3) Is not currently serving nor has he/she served within the immediate past two years on its awards committee or as an officer of the Association in other than an ex officio capacity; (4) Has compiled an outstanding record of community service, which, apart from his/her specific identification as a pharmacist, reflects well on the profession.

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Please see brief summary of prescribing information on following page.

1. FDA Orange Book 2004.

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Calendar

For more information about NCAP events visit www.ncpharmacists.org or call NCAP at 919-967-2237.

May 22: ***Pharmacy-Based Immunization Delivery Program***, Institute of Pharmacy.

May 24: ***NCAP Chronic Care Practice Forum Meeting.*** Holladay Healthcare, Winston-Salem.

May 28: ***NCAP Technician Review Seminar***, Jacksonville, NC.

June 11: ***NCAP Technician Review Seminar***, Fayetteville, NC.

June 12: ***NCAP Technician Review Seminar***, Greensboro, NC.

June 12: ***Pharmacy-Based Immunization Delivery Program***, Hilton Hotel, Greenville.

June 11-15: ***ASHP Annual Meeting.*** Boston, MA. For more information visit www.ashp.org

June 25: ***NCAP Technician Review Seminar***, Asheville, NC.

June 26: ***NCAP Technician Review Seminar***, Charlotte, NC.

June 26: ***Pharmacy-Based Immunization Delivery Program***, Catawba Valley Medical Center, Hickory, NC.

July 24: ***Pharmacy-Based Immunization Delivery Program***, Charlotte AHEC.

Sept. 9: ***Pharmacy-Based Immunization Delivery Program***, Wilmington Hilton, Wilmington, NC.

Sept. 10-11: ***North Carolina Pharmacy Practice Seminar.*** Wilmington Hilton, Wilmington, NC. More information to follow.

Oct. 15-19: ***NCPA Annual Convention.*** Fort Lauderdale, FL. For more information visit www.ncpanet.org

Oct. 16-18: ***NCAP Annual Convention.*** Sheraton Imperial, Research Triangle Park, NC. More information will be available soon.

Oct. 23-26: ***ACCP Annual Meeting.*** San Francisco, CA. More information at www.accp.com

Nov. 9-12: ***ASCP Annual Meeting.*** Boston, MA. For more information visit www.ascp.com

Dec. 4-8: ***ASHP Midyear Clinical Meeting.*** Las Vegas, NV. More information can be found at www.ashp.org

North Carolina Association of Pharmacists
Technician Review Seminar

This one-day review has something for all technicians:

- ✔ **Prepare for the Pharmacy Technician Certification Board Exam.**
- ✔ **If you are already certified, earn 7 hours of CE credit.**
- ✔ **The Board of Pharmacy requires that all new technicians complete a formal training program. This course fully meets the BOP training requirements.**

NOTE: YOU MUST REGISTER WITH PTCB BY MAY 27, 2005 TO TAKE THE JULY 23, 2005 PTCB CERTIFICATION BOARD EXAM. REGISTER ONLINE AT www.ptcb.org, OR FOR A REGISTRATION PACKET CALL PTCB AT 202-429-7576 OR NCAP AT 919-967-2237. TO ATTEND THE NCAP TECHNICIAN REVIEW SEMINAR YOU MUST REGISTER WITH NCAP, USING THIS FORM, AT LEAST 7 DAYS PRIOR TO THE PROGRAM YOU WISH TO ATTEND.

The availability of a review class prior to taking an exam is an advantage that most people would welcome. With new legislation recognizing the benefits of national certification of technicians, the advantages that this program provides will far exceed the minimal costs involved.

Over 98% of the Technicians who have taken this review course have passed the PTCB exam.

These success stories speak highly of the presentation materials and the instructors:

- Ted Spader, RPh, MSPhAd is employed with the Eckerd Corporation. He has worked at Somerset Medical Center, is the previous owner of Ringoes Pharmacy, Inc. and was previously a District Manager with Eckerd.
- Mark Sheppard, RPh is a Corporate Trainer with the Eckerd Corporation.

The NCAP Technician Review Seminar includes: • preparation for exam day • one hour of pharmacy law • basic math • dispensing calculations • hospital calculations • commercial calculations • hospital practice review • a review of the top 200 most widely used drugs including side effects, interactions and counseling tips

NCAP TECHNICIAN REVIEW SEMINAR REGISTRATION FORM

Please REGISTER AT LEAST 7 DAYS PRIOR TO THE PROGRAM you wish to attend or CALL FOR AVAILABILITY.

The review will be held from **8:30am to 5:00 pm** with a one-hour break for lunch (on your own). Please bring a calculator and a pencil.

CHECK THE LOCATION AND DATE you plan to attend:

❒ **Sat. May 28: Jacksonville,** Coastal Carolina Community College, Business Tech Bldg. Rm 101

❒ **Sat. June 11: Fayetteville,** Fayetteville Tech Comm. College Rm CEC118

❒ **Sun. June 12: Greensboro,** Greensboro Moses Cone AHEC Rm 1040

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North Carolina Pharmacist

Volume 85, Number 3 ...applying drug knowledge to improve health Summer, 2005

Opportunities for Independents

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North Carolina Pharmacist

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Inside

Please Keep Your Membership Record Current
If your contact information (address, phone, e-mail, etc.) changes please visit the Networking Center at www.ncpharmacists.org to update your membership record. If you don't have internet access please call NCAP with any changes you may have. Your help will be greatly appreciated.

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The Sunday programming is dedicated to **break-even analysis for the community pharmacists**. There will also be Sunday evening Concurrent Sessions on **Medicare Part D** and **Acute Decompensated Heart Failure**. Monday morning's plenary session includes **"significant papers," the methamphetamine issue in North Carolina,** and **follow-up on the IOM report.** That afternoon there will be **concurrent sessions** for **students, technicians,** and each of the **NCAP Practice Forums**. A plenary session is scheduled for Tuesday and includes, a **"significant papers" presentation**, a **"panel presentation" covering the Medicare Modernization Act from the perspective of the three Practice Forums**, and a presentation on the **diabetes and cardiovascular components of Metabolic Syndrome.** Scheduled for the afternoon concurrent sessions are **topics for all four Practice Forums**, including presentations on **probiotics & complementary/alternative medicine. Join us for North Carolina's largest pharmacy meeting.**

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Special Sunday Program

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Sunday, Oct. 16, 2005, Sheraton Imperial, RTP, NC

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If I buy new equipment, how much will I need in sales to cover the cost?
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- **Beyond Survival: Seven Steps to Fiscal Fitness**
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  Speaker: Carl G. Forssen has gained recognition as founding President and CEO of a successful startup bank. He brings an in-depth understanding of the financial challenges that confront a business owner and has been a featured speaker for such clients as the National Community Pharmacists Association, Ace Hardware, Burger King, Anheuser-Busch, Pepsi Americas and numerous banks throughout North America, Australia and New Zealand.
- **Medicare Part D: Implications for Pharmacists**

Watch for your Convention brochure in the mail.

Fred Eckel

Independent Pharmacy is Alive and Well

This year is a little more than half over. As I age it seems like each year goes by more quickly. Perhaps it is just that I am not able to get as much done as quickly so it just seems like the years go faster. The six-month interval provides me an appropriate opportunity to report on NCAP's progress and pharmacy's challenges.

First, some good news. As featured in this issue, independent pharmacy is alive and well. Reports I receive from many sources suggest that the resurgence of new independent store openings are occurring everywhere, including North Carolina. NC Mutual Drug Company, who helps sustain independent pharmacists and supports the opening of new stores, is featured in this issue. We focus on Mutual Drug because they are a homegrown company playing an important role in the North Carolina pharmacy community, but the major wholesalers offer similar programs and we recognize their contributions too.

At many schools of pharmacy, including the three in North Carolina, a small but growing number of students are expressing interest in a career in independent pharmacy. Mutual Drug and its members have been playing a role to enhance this interest, including help in offering an elective course at pharmacy schools in their service area. One of our Life members once told me that "as goes independent pharmacy, so goes NCAP." However, if you practice in another facet of pharmacy you might take some exception to this statement. When pharmacists have the option to go into business for themselves it adds a dynamic to the profession. I have also seen that people whose livelihood is directly dependent on what they do have a great passion for the profession. When there is a real need they can be counted on to respond. As NCAP tries to unite the enthusiasm of independent pharmacists with the professional insight and experiences of hospital and consultant pharmacists we have a powerful resource to truly advance North Carolina Pharmacy and benefit North Carolina citizens. Getting NCAP's professional priorities right and finding the best way to focus our energies is still a work in progress.

Mid-year Progress Report

The NCAP Board gave us four strategic directions for 2005 to 2007.

1. Work with the Board of Pharmacy to advance pharmacy practice.

We are attending the monthly BOP meetings and posting a meeting summary on our Web site. A Tripartite committee composed of representatives from the three schools of pharmacy, the Board of Pharmacy, and NCAP recommended that the number of required CE hours for relicensure be increased to 15 hours per year. This was approved unanimously at the Pharmacy Leaders Forum and introduced as part of the BOP fee increase bill, House Bill 1349. The Technician Task Force is finalizing wording to recommend an enhanced role for selected technicians to present to the BOP.

2. Reorganize the Practice Forums to meet the unique needs of different pharmacy practitioners.

The Ambulatory Care Practice Forum has changed their name to Community Care Practice Forum because they feel this better identifies their focus. We fully support their efforts to revitalize the largest NCAP Practice Forum. We continue to work with the Chronic Care Practice Forum to successfully integrate NCASCP into NCAP.

3. Promote patient care initiatives.

NCAP has conducted regionally focused Immunization Certificate Programs to help pharmacists prepare for the flu season. Our 10 regional programs prepared over 300 pharmacists to become Outcomes Certified to be able to bill for patient care services to Community Care Rx Drug Card patients. *Pharmacy Times* published a supplement in June entitled "Beyond Asheville." NCAP will be sharing this supplement with key individuals in North Carolina in an attempt to interest them in helping us implement more Asheville-type projects.

4. Promote Leadership Development.

The Student Pharmacists Leaders Forum was held in Pinehurst, NC April 16. The second annual program brought over 50 student leaders from the three schools of pharmacy together for education, socialization and planning. This successful event will become an annual event. It has been supported by our chain pharmacies.

We conduced the 6th Annual Residency Conference on July 15 at the Grandover in Greensboro with over 100 attendees. One goal of the Conference was to help aquaint these future pharmacy leaders to North Carolina pharmacy and NCAP.

Your staff continues to actively promote North Carolina pharmacy. We feel privileged to work for you and are committed to making NCAP the best organization in pharmacy. Thank you for continuing your membership.

North Carolina Association of Pharmacists
109 Church Street
Chapel Hill, NC 27516
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Davie Waggett

Dear NCAP Members,

Independent Pharmacy. It has a great ring to it. Independent pharmacy is serving my patients very well, and me included. Independent pharmacy is fun. Yeah, I love it. When I first heard that there would be a feature article on opportunities for independent pharmacists, I was excited to think that I could write to possibly add something to what others had to say.

What is Independent Pharmacy, and where did it come from? Well, it's that blend of the original practice of pharmacy and the business world put together to function in your neighborhood. It is a lot of what you see in Norman Rockwell's portraits of pharmacy.... the pharmacist mixing up something that the Doc has ordered, the pharmacist on one knee cleaning up a skinned knee of a child or one of his patients, the pharmacist in a lab jacket with stuff sticking out of all the pockets, and the pharmacist talking to one of his patients, not only about his ailment but also about his family or his fishing trip. Yeah, we get to do all that stuff in our community settings, if we will. Our patients love it and it makes our day enjoyable and rewarding. My days are not complete unless I avail myself to help someone feel, or do better.

So what are the opportunities for our independent pharmacies to exist in the fast-paced world of filling hundreds of prescriptions each day, with competition on every corner? I believe that the opportunity exists in almost every town that doesn't have an independent pharmacy. Maybe not the smallest of towns, but certainly in communities that have enough population to support the expense of the operation plus yield a reasonable profit for the owner to step out on his/her own (there are some wonderfully run pharmacies in several very small communities that are very successful and provide a great service for the surrounding area). Mid-size and large towns, as well as major cities in North Carolina certainly have a place for an independent community pharmacist to establish a niche for a particular neighborhood and for particular services being offered that can't be found at other pharmacy locations in that area. Many pharmacists are establishing specialty niches to offer to the public, niches that are usually only available in independent pharmacy. These areas include diabetic care and counseling, fitting and selling shoes for diabetics, asthma care and related products, oxygen therapy with in-home delivery systems and respiratory therapists on staff, smoking cessation counseling, specialty compounding, CPAP/BiPAP, home health care equipment and supplies, wound care management, immunization clinics, plus many more areas. So yes, there are opportunities to add benefit to your community.

Can you get it done? Well, of course, but you must be smart about it and you must be willing to step out of the comfort zone of being an employee. Banks and financial institutions are willing to invest in a good business plan. Wholesalers are willing to help with initial stocking and favorable terms. Location, location, location.... yes, that is such an important factor in the success of most retail businesses. They gotta' see you, and they need easy access (convenience). Be willing to put some cash into advertising a new venture, especially if you are opening in a mid to large size population that is spread out. Visit the Docs and let them know who you are, where you are, and what services you plan to offer.

Well it can't all be that easy, can it? A lot of it is, and it is fun. However, the downside is what is happening on the insurance level and the government level with regard to third-party reimbursement. We have to get paid for what we do, or we will soon run short on cash to operate. This is the most challenging part, at present, to running and successfully operating an independent pharmacy. We will soon be approaching the crossroads that will cause pharmacies (all community pharmacies) to examine their practices and their budget items to see what can continue on. It will be a great challenge for all of community pharmacists to adapt to upcoming changes and still be able to provide the services that are needed and wanted by our patients.

Independent Pharmacy. It still has a great ring to me. I wouldn't want to be anywhere else, and my plan is to not be anywhere else. It's not for everyone, but for those who have that feeling that they belong in this part of pharmacy. Opportunities still exist for those with that entrepreneurial spirit and that love of pharmacy. Good hunting for that right spot!

Davie Waggett, RPh
President

...applying drug knowledge to improve health

Opportunities for Independents

There are currently 581 active independent pharmacies in the State of North Carolina. About 160 new permits have been issued to independent pharmacies since the year 2000. We asked two independent pharmacists and a pharmacy wholesaler to give us their opinions about the future of independent pharmacy practice, and how and why they decided to become entrepreneures. We focused on NC Mutual Drug because they are a homegrown company, but the major wholesalers in North Carolina offer similar programs and we recognize their contributions as well.

My career in pharmacy began long before I knew I would become a pharmacist. My father was a pharmaceutical sales representative, and my mother worked part time as a bookkeeper at a local independent pharmacy run by Frank Yarborough and Jere Johnson. Mom also did a fair amount of volunteer work at the Institute of Pharmacy. Although I began making my own money via an afternoon paper route at age 11, my mother decided that was not enough to help pay for college and helped me land a part-time job at her then former employer doing deliveries and stocking shelves during high school. I thought I wanted to go to the school of medicine, yet God thought differently. After a solid yet unremarkable freshman year at UNC-CH, I realized that med school was going to be a lot of serious studying and a lot of serious loans that would consume my life for a number of years to come. Serendipitously, I had taken the correct courses to be accepted into the School of Pharmacy, and I never looked back. During the summer of my junior year, I was fortunate to land a job in Morehead City with Larry B. Good at his store called Good Drugs. I saw many of the same caring characteristics in Larry that I had seen in Frank and Jere, and I realized that I would feel rewarded if I could help people the way they did. Thus, the passion ignited. I focused the remainder of my college career toward learning everything I could about operating my own retail store, as school still offered these classes in my era. After college, I did a brief stint with a chain pharmacy, yet independent pharmacy held my desires, and with the help from my Mom's connection at the Institute of Pharmacy, I landed a job with an independent in Raleigh called Hayes-Barton Pharmacy owned by Bill Wilson. Although Bill is 30 years my senior, we are usually on the same page with respect to our philosophies of pharmacy. He has been a great mentor, boss, employee, and friend through the last 22 years of my career. I hope I can be all that to someone myself one day. I was also fortunate to develop some friendships outside of pharmacy during college with a now tax accountant and a now tax-business planning lawyer who were both very helpful in advising me on my first business purchase, and from whom I continue to garner advice to this day.

The latest segment in my career has been growing a small group of pharmacies along with a college classmate, Dan Hardy. Dan and I started a company called Hardy-White Pharmacies and we own four pharmacies between us at this time, with a fifth in the works. We feel this is a prime time to become involved with ownership of a community pharmacy with respect to the fact that many of the

independent pharmacy owners are close to, or at, retirement age. Many of these owners should consider a junior partner to carry their practice forward, or consider selling their practice to someone who is willing to groom a pharmacist with minimal business experience to become the owner. Also, there are more than a handful of pharmacy owners (including us) who desire to expand their practice, yet need entrepreneurial-minded pharmacists to manage and possibly buy a portion of a satellite pharmacy. Many of the rural areas of North Carolina remain underserved in healthcare, and finding the right opportunity in this setting could be very rewarding.

Many factors have brought a renewed interest to the pharmacy profession. The sheer size of the overall healthcare industry guarantees a certain amount of public exposure, and as the profits of pharmaceutical companies have been at the forefront of the media, our connection to these products cannot be overlooked. Fortunately, pharmacists have become more politically proactive to help tout our profession. With the advent of Medicare coverage of prescriptions and of medication management, and with the first baby boomers coming into this coverage, I believe we will see a number of new models of drug management surface over the next few years. Entrepreneurial clinical pharmacists will be on the leading edge of these new models and will be handsomely rewarded as they help solve many of the problems of our current dispensing model which has been handcuffed by the current insurance/PBM model. The successful community pharmacist entrepreneur will choose the best solutions and implement these into his/her practice.

I like to think that each of the pharmacists working for our company will strive to gain knowledge every day that will help improve patients' health and will constantly be thinking of a better way to provide our services in order for us all to be successful. If you think you may be interested in owning your own practice, I would ask yourself if you are willing to take a calculated risk to seize an opportunity that you desire in order to be responsible for your own decisions that will ultimately be very successful if you remain persistently dedicated to your goals.

My vision of pharmacy a few years down the road is that we will all be implementing as many technological devices as possible to dispense the medications efficiently. I think the community pharmacy model will survive, with a few twists. I think pharmacists will perform many of the same knowledge base tasks as they do today, yet the revenue stream for these tasks will be different. Community Pharmacy contracts of the future may also include providing certain levels of counseling, disease state specific education, and healthcare coordination of services. Belonging to a successful network of pharmacies will be important, and I feel confident that our company's participation in NC Mutual Wholesale Drug Company will help us achieve our goals. Pharmacists are still the most accessible healthcare providers, and as long as there are prescriptions dispensed, someone will be operating a community pharmacy to provide those prescriptions.

-Tim White
Hayes-Barton Pharmacy
Raleigh, NC

Independent pharmacy is not dead or even dying! In fact in my geographic area it is expanding. I think the single greatest opportunity for independent pharmacy is provided by what was once considered the independent's greatest nemesis...chain pharmacies. I opened my pharmacy because as a consumer I got tired

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Independent Pharmacy Statistics

(National Statistics from 2004 NCPA-Pfizer Digest)

- Independent pharmacy: $77 billion marketplace
- Independent prescription sales: $67 billion
- Independents dispense 1.3 billion prescriptions annually- 41% of the retail prescription market
- 88% of annual sales are prescription medicines
- Average independent pharmacy sales: $3.2 million- up 12% over 2002
- Average prescription sales: $2.8 million- up 10% over 2002
- Average prescription per pharmacy: 56,100 annually, 180 per day
- There are 23,956 single-store independent pharmacies, independent chains, independent franchises, independent long-term care and home I.V. pharmacies, and independent pharmacist-owned supermarket pharmacies - - 42 percent of the nation's 57,208 pharmacies
- 24.6% of independent owners own two or more pharmacies
- Average multi-store owner owns 2.9 pharmacies
- Overall the average independent owns 1.5 pharmacies
- The top services offered in 2003 were:
  - delivery (85%)
  - charge accounts (85%)
  - nutrition (85%)
  - durable medical equipment (75%)
  - herbal medicine (67%)
  - and compounding (62%)
- E-mail access in the pharmacy: 89%
- Internet access in the pharmacy: 96%
- Pharmacy Web site: 46%
- Offer refills via Web site: 63%
- Sell OTC products via Web site: 37%
- Average independent employs 2.6 pharmacists (including owner)
- Average independent employs 3.4 technicians
- 52.7% of drugs dispensed by independent pharmacies are generics

of waiting three hours for my prescription to be filled, or constantly having to make two trips to the pharmacy for inventory shortages. I was willing to bet that many other customers felt the same way, and that they were hungry for the service that I remembered my hometown pharmacists provided. Also, patients are taking a more active role in their healthcare today, and they want a pharmacist they can talk to and interact with on a regular basis. Reimbursement rates may not be what they were in the past, but by using NC Mutual Drug as my wholesaler, I am able to acquire my inventory at a price that still provides me a reasonable profit. My store has been open for 18 months, and I was able to draw salary comparable to most chain pharmacists by six months, and was showing a modest profit by the end of the first year.

Dave Marley, owner of Marley Drug in Winston-Salem.

I think in the past there has been a misconception perpetuated by some pharmacists, and even some in academia that it was impossible to open a successful independent pharmacy. Older pharmacists who previously made a living filling 70 scripts a day may have been unwilling or unable to increase their volume to compensate for decreasing reimbursements. When I was in pharmacy school many of my instructors looked down their nose at retail pharmacy and discouraged students from pursuing any retail pharmacy career. Despite the nay-sayers, there have been five new independent pharmacies opened in Forsyth County in just the last three years, and one more is scheduled to open in the fall. I think the reason for this is two-fold: a) working conditions in many pharmacies are such that pharmacists are realizing they want more control over their work environment and practice style and b) to coin a phrase "there's gold in them there hills," i.e., there's money to be made owning your own store!

One reason I went into this field is because my wife and I had just had our first child, and I wanted to make more money and work less hours. A friend of mine, Ike Vlahos, had opened a pharmacy about a year earlier and he provided the necessary encouragement that independent pharmacy could be successful. On June 1, 2003 I started writing a business plan to take to the bank for a Small Business Association loan. I took a $145,000 loan from the bank payable over five years, and another $100,000 of my own. We opened the store on November 3, 2003, and last week we filled just under 1000 prescriptions! Our hours are Monday thru Friday 9am-6pm and Saturday 9-noon.

I can't stress enough how important it was for me to align my business with our wholesaler. I truly do not think I could have had

such a seamless process of getting the store open were it not for my NC Mutual Drug sales representative, Dan Houston. They allowed me to stock my store with an opening inventory, but did not require payment on that opening order for 12 months. This feature was critical in that it allowed us time to generate the cash flow needed to cover inventory growth and insurance receivables during the first 12 months. I also visited other independent pharmacies in the area who were all very helpful and willing to share ideas on getting a new store up and running. I spoke with a couple of franchise pharmacies but couldn't justify paying a monthly franchise fee for 20 years for things I felt I could do myself.

We are currently in a 1400 sq foot space in a grocery anchored strip mall. When our lease is up in three and a half years, I plan to build a free-standing 4000 sq foot store with a DME and medical supply showroom. If all goes well, I'd like to partner with other young entrepreneurial pharmacists and open a couple of other stores as well.

If you are interested in entrepreneurial practice start putting some money aside now!! If you are a new graduate, take that $10,000 sign-on bonus your current employer gave you and put it in the bank. I think the biggest stumbling block for many young pharmacists wanting to open a store is obtaining the required capital needed to cover opening expenses, inventory growth and insurance receivables. I was repeatedly reminded that the number one reason new businesses fail is under capitalization (not having enough money). First and foremost, develop a business plan that has a reasonable projected cash flow forecast to determine how much money you will need to cover your expenses and the prescription volume you can expect to generate in the first 12 months. With some money in the bank, a good credit rating, an established relationship with a bank, a good business plan, and proper planning you can open a new store in about six months.

- Dave Marley
Marley Drug, Winston-Salem, NC

Today, independent pharmacies are increasingly diverse in character. They include single-store operations, independent chains, and independent, franchised stores. This diversity also extends to the types of services offered to their customers. Many independent pharmacists have incorporated specialty services such as home healthcare, disease management and compounding to create a unique pharmacy practice.

For both pharmacy school undergraduates and practicing pharmacists, diversity and freedom serve as key attractions to independent pharmacy. Having the opportunity to focus on areas of interest greatly enhances the level of job satisfaction. Additionally, entrepreneurial pharmacists are often motivated by the risk/reward of operating their own business. Independent pharmacy owners can enjoy greater long-term earning opportunities. Earnings are in the forms of owner compensation, annual net profits earned by the pharmacy, and the market value of the pharmacy at the time of sale.

For many years, the belief existed that pharmacy customers were best served by having their prescriptions filled at a chain pharmacy. There is now evidence to indicate this trend has been reversed. In their October, 2003 issue, *Consumer Reports* surveyed more than 32,000 of its readers. Regarding customer satisfaction they reported:

"Independent stores, which were edging toward extinction a few years ago, won top honors from *Consumer Reports* readers, besting the big chains by an eye-popping margin. More than 85 percent of

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customers at independent drugstores were satisfied or completely satisfied with their experience, compared with 58 percent of chain drugstore customers."

In the same issue, *Consumer Reports* conducted a price study using five popular prescription drugs showing that the average costs for the five items were lower at the independents than at the drug chains. Today, independents are offering competitive prices with superior service. These two factors have translated into significant sales growth for independent pharmacies.

For pharmacists who are interested in owning their own pharmacy, North Carolina Mutual Drug (Mutual Drug) offers an array of services to assist the prospective owner. Store ownership can be achieved by matching a prospective buyer to a prospective seller or by directly starting up a new pharmacy. Based on geographic area or type of pharmacy desired, we strive to match prospective buyers to pharmacy owners who desire to retire. Under this approach, a seller and buyer may join into a junior partnership agreement allowing a planned transition of ownership. This approach can be a win/win situation in many cases. The seller can gain a motivated business partner capable of growing the business who can also buy into the business over a few years thus, smoothing out the capital requirements to meet the agreed upon price.

Under a startup situation we can assist in store location, design, inventory management, merchandising and advertising. Our staff is experienced in assisting the new pharmacy owner with the tasks required to open a pharmacy. This includes everything from obtaining the required pharmacy permits to planning the grand opening. For example, we have significantly reduced the work required for a new pharmacy to sign pharmacy provider contracts. Under a network agreement, Mutual Drug co-op pharmacies can participate in a pharmacy network which reviews and signs the contracts on behalf of the participating pharmacies.

The new owner is able to rely on our experience and resources. Once the pharmacy is up and running, we can help with promotions, health screening, back office operations such as human resources, as well as education, not only for the pharmacist but also for the pharmacy employees. It is our goal to apply these resources to ensure the success of the new pharmacy. While new startup failure rates can be quite high in many industries, Mutual Drug has experienced a 98% success rate in new pharmacy startups. We believe this rate of success is due to the assistance and resources that we make available to new pharmacy owners.

We are active on a number of fronts in representing the interest of independent pharmacists. Our history and future is tied to the success of the entrepreneurial pharmacist. We have been working with the schools of pharmacy to promote career opportunities in community pharmacy. This has occurred through sharing information at career day forums, teaching classes and funding the development of courses to enhance the student's business skills. We are encouraged by the renewed interest many pharmacy students have demonstrated. We look forward to working with these future pharmacists.

Often we find the qualities that have enabled the entrepreneurial pharmacist to be successful with their business carry over into leadership roles in their communities and in the pharmacy profession. At Mutual Drug, we are proud that many of these pharmacists are working hard to ensure the future of community pharmacy.

All signs indicate a bright future for independent pharmacy. We would encourage any new pharmacist to seek out employment opportunities with an independent pharmacist as a first step in the development of a rewarding career in this key healthcare delivery profession.

- Dave Moody
NC Mutual Wholesale Drug Company

Pharmacy's Leadership Challenge in North Carolina

Many of the professions are noting a lack of interest by young practitioners in assuming leadership and managerial roles. This has the potential of creating a void as current leadership ages and retires. Sara White, ASHP Foundation Scholar in Residence, has presented information on the impact of this issue in pharmacy. She conducted a national survey of experienced directors of pharmacy, clinical supervisors, and younger staff pharmacists. Sara concluded that there is a serious pending shortage of pharmacy leaders/managers and that the profession needs to take specific action if we are to prevent this pending crisis.

From review of her data, Ms. White determined that not only are too few new practitioners entering pharmacy to meet the positions available, but there is also a lack of practicing pharmacists who desire to become pharmacy managers/directors. The reasons that were cited in her survey are that current practitioners do not want to give up their clinical practice; they do not want to deal with personnel issues; and they think there are too many competing responsibilities for the compensation.

When current directors were asked about their contributions and reasons for continuing to serve in their position, directors reported sense of accomplishment, freedom, ability to influence decisions, and maintaining interdepartmental relationships to be what they liked most about their work. Job stress, finding funds and people for automation, keeping salaries competitive, and retaining adequate number of staff were the main dissatisfiers. The middle managers in her survey enjoyed making an impact on patient care, solving problems, having a variety of work, and helping staff learn. They were frustrated with stress, HR functions, balance with life/work, and having little time to think.

After analyzing the data, Ms. White recommended that the profession do the following:

- Evaluate generation and gender shift issues on supply and effectiveness of leaders.
- Investigate Middle Managers having to give up clinical practice (add support positions such as personnel manager and financial analysts for pharmacy departments, etc).
- Develop more advanced pharmacy practice management degrees and specialized residencies, and add back practice management into Pharmacy Practice residencies.
- Ask practicing pharmacists to formalize mentoring and leadership experiences when teaching new practitioners in Schools of Pharmacy.
- Promote the Chief Pharmacy Officer concept instead of a reactive Pharmacy Director position.
- Allow new practitioners with "administrative interest and flair" to serve in leadership and change agent positions earlier in their careers.

At the NCAP Acute Care Practice Forum in March 2005, data was presented from North Carolina Pharmacy Managers and Clinical Coordinators who vacated their positions for new opportunities. It appears that former Pharmacy Directors left their positions primarily due to stress and dissatisfaction with balance of life/work issues (Table 1). Many moved back into patient care; however, the desire to practice was not seen as a motivator, but as an option. Tim Giddens, who conducted this survey of colleagues, suggested that the position of Pharmacy Director is a position not many people want, and indicated a need to re-evaluate and re-engineer the role of the Director. With other personnel assuming more of the operational issues, the Director could focus less on management and more on leadership responsibilities. He also supported many of Sara White's recommendations, particularly that the Schools of Pharmacy re-establish a Masters level degree in Institutional Pharmacy Administration and that ASHP Pharmacy Practice Residencies address the need for increased organizational practice management competencies and modify the current residency standards to reflect that change.

Jean Douglas surveyed Clinical Coordinators in the state who had left their positions. The reasons they left were in fact very similar to the results with Directors (Table 2). Job stress, balance of life/work, too many responsibilities, limited resources, and personnel issues were common reasons given. Interestingly enough, some did leave to accept more responsibility. Four of nine became Directors/Managers in their next position. Jean suggested that now with the PharmD degree being the entry-level degree being conferred, most pharmacists entering the profession may be more focused on patient-care activities, and less willing to move to what may be perceived as a pure managerial role. Perhaps one solution is a mixed-practice model, with pharmacists incorporating both clinical and managerial duties into their job as other healthcare providers have successfully done. This would certainly help share the burden with directors and clinical managers.

The leadership crisis is not unique to pharmacy. Other industries are facing similar discussions and concerns, with the future being impacted by the lack of succession planning now. In the case of Pharmacy, without strong leadership with a vision, we will lose our position of promoting patient safety and driving the medication safety movement in the U.S. One pharmacy leader has said that for us to maintain our strong position in medication management, we need to build strong pharmacy leadership now and over the next five years. He says that each of us is responsible for making certain that leaders will be there when we leave the profession and retire. He describes the formula for leadership development:

Leadership Development = V+C+L

(variety of experiences + challenging assignments + the ability and willingness to learn)

When you think about his equation, you realize that this is something that each pharmacy manager or supervisor of pharmacists and pharmacy technicians can do today. Give your direct reports the experience, challenging assignments, and support they need to learn new things. Pharmacy Leadership development can begin today.... with each of us.

A North Carolina Leadership Task Force has been formed by the NCAP Acute Care Practice Forum, and seeks participation from pharmacists from all practice settings and forums.

Our initial goals are to:

- Ask North Carolina Schools of Pharmacy to reinstate the Masters in Pharmacy Administration/Management degree program.
- Ask NC Pharmacy Practice Residency Directors to develop more experiential opportunities for pharmacy residents this coming year, and to work with ASHP to modify the Pharmacy Practice Residency standards to include more management and leadership objectives.
- Provide ideas for practice models that allow all pharmacists to have a motivating and stimulating practice, incorporating clinical and administrative responsibilities.
- Encourage directors/managers/clinical co-

ordinators to identify at least one potential young practitioner in their site to mentor for leadership roles.

- Work with Schools of Pharmacy and Business Administration to develop both didactic and experiential opportunities within the PharmD curriculum that would help develop the skill set needed for practice management.
- Offer leadership development programs at most NCAP programs, with CE credit.
- Develop a list serve for pharmacists in all practice settings to share ideas, ask practice questions, and seek answers to practice issues, etc.
- Encourage and assist pharmacists to develop leadership skills.

To join the NC Leadership Development Task Force, please contact Tim Giddens 910.671.5176, gidden01@srmc.org or Jean Douglas at 336.832.8137, jean.Douglas@mosescone.com. We welcome your ideas and participation!

Survey Results of NC Pharmacy Directors

Ten Pharmacy Directors who left their position in acute care institutions were surveyed to identify contributing factors. Average 24 years of experience, average 54 years of age. The majority stayed in pharmacy practice after leaving the Director position.

- 100% of Directors indicated that Pharmacy School and a Pharmacy Practice Residency would not prepare you for a director position.
- 80% of Directors indicated formal post-graduate training (MS, MBA, or MPH) was necessary preparation for the position in most hospitals.
- 8 of 10 took pharmacy positions in patient care.

Survey Results of NC Clinical Coordinators

Nine Clinical Coordinators who left their positions in acute care institutions were asked for the reason they changed positions. Average 6 years of experience, average 40 years of age.

- 100% said that Pharmacy School did not prepare them for the administrative responsibilities of the Clinical Coordinator position with continuing education and experience helping more.
- 33% stated formal post-graduate training (MBA, MHA, MPH) was needed to fulfill the position.
- 56% were unable to practice clinical pharmacy when they left their position.
- Positions accepted included:
  - 4 of the 9 returned to clinical specialty practice
  - 1 of the 9 chose an Educational Liaison position with industry
  - 4 of the 9 accepted manager and director positions. ❖

About the Authors...

Tim Giddens, M.S., is Director of Pharmacy and Research Services at Southeastern Regional Medical Center in Lumberton, NC

Jean B. Douglas, BS, PharmD, FASHP, is Pharmacy Clinical Coordinator, Moses Cone Health System, The Moses H. Cone Memorial Hospital, Greensboro, NC.

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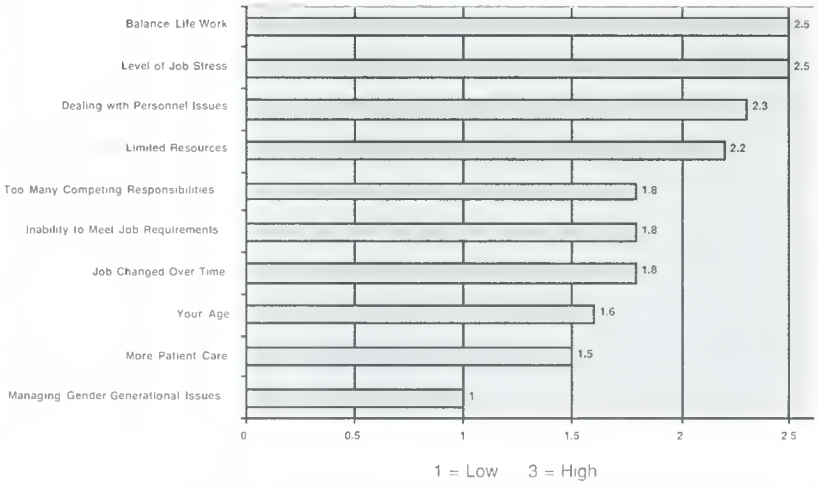
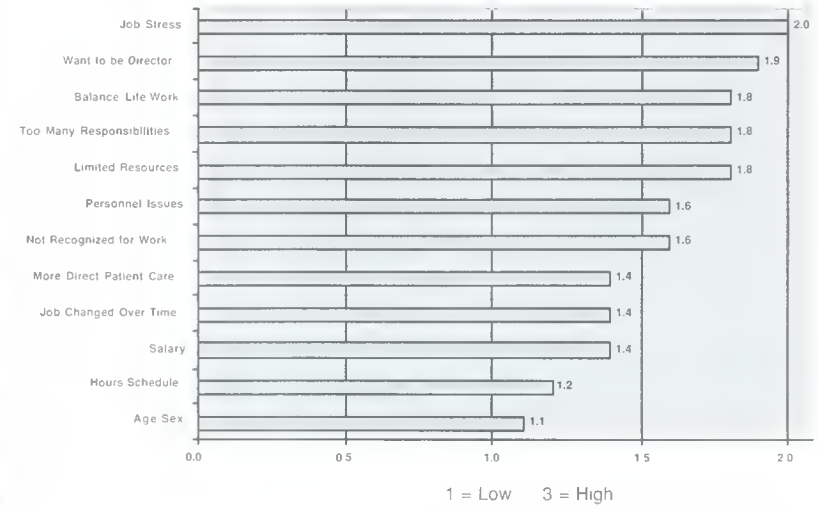
Table 1: Reasons Directors Left Position



Reasons Clinical Coordinators Left Position



Technology Only As Perfect As Its Users

by Bob Cisneros, PhD

The use of technology in pharmacy practice is a necessity. Technology is especially crucial now, as the number of written prescriptions has grown dramatically while the increase in number of pharmacists has not kept pace. The amount of information regarding new drug products has likewise increased. For example, the PDR was less than 300 pages in 1947 and in 2004 was over 3,500 pages.

In most pharmacies today, the use of technology is quite evident: automated dispensing/counting machines, robots filling patient medicine drawers, barcode-checking equipment, or advanced computer systems. Technology has the potential to ease the pharmacist's workload, allow the pharmacist more time to better care for his/her patients and save lives by identifying and preventing errors from reaching patients.

Technology has enabled the automation of many activities previously done manually (or not done at all). The *White Paper on Automation in Pharmacy* stated that automation has notable advantages over humans "in tasks that require tedious repetition, tiresome movement, intense concentration, immense memory retention, and meticulous record keeping."[1]

Too Good To Be True?

Because we *"have"* new technology doesn't necessarily mean that we are error-free. Modern technology does not alter the fact that its users are *human*. Humans must still initiate or interpret medication orders, enter medication orders into a computer, select the names of patients and drugs from a computer list, evaluate warnings, and restock dispensing machines.

In his book, *Set Your Phasers on Stun*, Casey described many tragic examples of mismatches that have occurred between the way a technology was designed and the way it was actually used.[2] The poisonous gas release at Bhopal and the deaths of three Russian cosmonauts during re-entry were caused in large part by such mismatches. When the creation of a technology does not consider the limitations and potential errors of its human operators, accidents can still occur. Casey believed that technology of the future will become more complex and will become "more, not less dependent on human capabilities and limitations."[2(p. 12)]

A study of community pharmacy medication errors by Flynn et al. found that the most frequent errors occurred in the preparation of new prescriptions.[3] The most common errors (40 of 77 total) were wrong instructions placed on the prescription label. For example, an inhaler to be used "four times daily" was labeled to be used "every other day." Would all barcode-checking systems have caught this mistake? In this case, prescription inspection failed.

Flynn et al. noted that computer entry errors such as these are often not the focus of technology but yet were the most frequent errors detected in their study.[3] These authors stated that it was important to "keep the original prescription (or an electronic representation of it) with the product and label throughout the filling process."[3(p. 198)] The potential problem with order entry and the fact that automated systems may not be able to detect all order entry errors has previously been recognized.[1]

New Technology and "New Errors?"

Koppel et al. recently studied the implementation of a computerized order entry (CPOE) system for physicians in a large teaching hospital.[4] Through interviews and surveys of physicians, the authors began to identify problems associated with the use of CPOE that included:

- Confusion over dosages listed on the computer screen.
- Difficulties in identifying patient and drug names.
- Problems with obtaining allergy information.
- Duplication of medications.

Koppel et al. noted: "CPOE systems can facilitate error risks in addition to reducing them. Without studies of the advantages and disadvantages of CPOE systems, researchers are looking at only one edge of the sword. This limitation is especially noteworthy because many problems we identified are easily corrected."[4(p. 1202)]

The findings of this study should not detract from the great value of CPOE technology and efforts being made to implement it. However, it should serve as a reminder that we cannot "fall asleep at the wheel." In the rush to embrace any technology, we must be aware that problems, especially unanticipated ones, will probably occur. Evaluation should be an important part of the adoption process of any technology.

MedMARxSM Findings

MedMARxSM is a voluntary, medication error-reporting program managed by the USP, to which healthcare facilities in the US can subscribe.[5] Extensive analysis of reported errors is done by MedMARxSM. The summary of results reported from 1999-2003 has been published.[5] Included in the report were sections devoted to medication errors that were related to computer entry, computerized physician order entry and automated dispensing devices.

Computer Entry (CE) Errors

CE errors were listed as one of the causes of error in 13.1 percent of the more than 200,000 error reports. Mistakes included the improper dose/quantity being dispensed, as well as wrong time, wrong patient and wrong dosage form errors. According to MedMARxSM, CE errors in 2003 were the fourth leading cause of reported errors. The majority of these errors did not reach the patient and 0.74 percent were reported as "harmful." Nursing and pharmacy personnel were primarily involved with these errors.[5]

Special Continuing Education Supplement

In order to better serve our members, NCAP will mail a special CE Supplement only to members who request it. If you would like to be added to the mailing list for CE contact Teressa Reavis at teressa@ncpharmacists.org or call 919.967.2237 ext. 22.

Contributing factors to these errors were identified as distractions, workload increases, and inexperienced or insufficient staffing. The report recognized that computer entry is a serious activity and that personnel should be shielded from distractions. Adequate training on the system was considered essential. [5]

Computerized Physician Order Entry (CPOE) Errors

Twenty-one percent of facilities reported using CPOE to some extent. Sixty-seven percent of CPOE errors reported (or 1,729 errors) were associated with the prescribing process. Examples of CPOE errors included selection of wrong patient, drug, route of administration or dosage form. CPOE-related errors also occurred in the transcribing/documenting, dispensing, administering and monitoring phases. [5]

Hicks et al. noted that the findings "reflect a gap between CPOE's potential to reduce error and the reality that its complexities and implementation challenges can create new errors." [5(p. 73)] Further, it was felt that "erroneous orders generated through CPOE may be prepared, dispensed, and administered with little or no additional validation or interpretation by other practitioners, thus creating the potential for errors to proceed through the medication use process." [5(p. 77)] Frequent causes of CPOE error included knowledge deficits of how the system functioned, computer entry errors, performance deficits, abbreviation-related problems and calculation errors. Also implicated were distractions, staff inexperience, workload increase and computer or network failure.[5]

Automated Dispensing Device (ADD) Errors

Errors related to ADD's represented 4.1 percent of all submitted error reports to MedMARxSM. **About 31 percent (!) of these errors reached patients and 1.3 percent of the errors resulted in harm.** The three most frequently reported error types were the dispensing of an improper dose or quantity, wrong drug or drug omission.

A source of many of these errors was felt to be the improper filling or restocking of the ADD. Other causes of ADD errors were thought to include such factors as: procedures not being followed, poor documentation, inadequate system safeguards, and computer entry problems. Hicks et al. suggested that all pharmacies have policies addressing access to the devices by personnel, restocking procedures, and the return of unused medications to the device. [5]

Summary

The development and use of new technology is critical. We need technology advances to cope with the increasing demands of pharmacy practice and to ensure the safety of our patients. However we cannot allow technology to let us believe that its mere presence ensures an error-free system. We still need human vigilance, now more than ever. ❖

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5. Hicks RW, Sanell JP, Cousins, DD and Williams, RL (2004) *MedMARxSM 5th Anniversary Report: A Chartbook of 2003 Findings and Trends 1999-2003* Rockville, MD: USP Center for the Advancement of Patient Safety.

USP Adopts New Resolutions at 2005 Convention

by Stephen Eckel

I was given the opportunity to represent NCAP at the United States Pharmacopeial Convention held March 9-13, 2005. The United States Pharmacopeia (USP) meets every five years as an official convention. This convention had over 300 representatives from at least eight different countries. Many people associate USP with USP-797 (affecting all of pharmacy presently), but there are many other ways in which they affect and promote the profession.

The USP is dedicated to promoting "the public health by establishing and disseminating officially recognized standards of quality and authoritative information for the use of medicines and health care technologies by health care professionals, patients, and consumers." They accomplish this mission through numerous avenues such as publishing the USP-NF (national formulary) that provides official monographs and standards for all marketed medications and some nutritional supplements. They also publish and disseminate the USP-DI (drug information), which is a "comprehensive collection of clinically relevant, established information about each drug." The first volume provides a monograph for each medicine and compares individual agents within a class review. Another volume provides individual drug monographs written for the public to comprehend. A final volume contains approved drug products and legal requirements. USP also maintains MedMARx®, a national database with a goal of reducing hospital medication errors. All hospitals are eligible to become members of this anonymous service. After becoming a member, all medication misadventures must be added to the database for others to view and learn. It allows hospitals to benchmark themselves against other comparable institutions and to view variances in hospitals with the goal of recognizing potential problems in their operations. These are a few of the major initiatives that USP coordinates to fulfill their mission statement.

Some of the notable issues that USP has recently undertaken include transferring the publication of USP-DI to Thompson Publishing. USP will no longer be responsible for the management of the content. However, USP will be publishing their first Pharmacists' Pharmacopeia, due out this summer. This will contain both excerpts from the USP-NF and authorized text on issues impacting pharmacy. Finally, USP is taking its standard setting process overseas as it continues to promote the harmonization of pharmacopeias. They are planning to build an office in India to helping advance standards there. USP is also working with other countries to promote harmonization of compendial standards within their drug production and testing.

At the 2005 convention, numerous resolutions were adopted that could have a profound impact on the profession. These resolutions are essentially strategic planning guides that USP will use to evaluate future directions for the next five years (until the next convention). The following are highlights of resolutions adopted by the convention which are of interest to NCAP members:

- Work with stakeholders to continue to develop packaging, shipping, distribution, and storage standards and practices that ensure the integrity and safety of all therapeutic products through the distribution and dispensing system. USP further resolves to support educational and allied activities, at all levels of distribution, dispensing, and administration (manufacturer through patient) concerning the integrity and safety of therapeutic products.
- Expand its work with appropriate parties involved in compounding, including practitioners, FDA, state boards of pharmacy, and other regulatory authorities, to support and disseminate information about science-based compounding practice.
- Collaborate with appropriate partners to continue establishing standards for labeling and nomenclature that support the safe and proper use of therapeutic products, including but not limited to initiatives that:
- Provide references for the identification of multi-ingredient products.
- Address recurring medication errors, particularly in the area of look-alike/sound-alike names, labeling, and packaging.
- Reduce medication errors particularly in the area of look-alike/sound-alike names, by encouraging the use, in the practice setting, of only the generic names for new single-active-ingredient products marketed after January 1, 2006.
- Encourage the uniform use of USP-NF dosage form nomenclature.

Hopefully, by adopting and acting on these resolutions, USP will continue to help pharmacy reduce medication errors and promote product integrity of marketed substances. ❖

"Representing NCAP was an educational experience for me as I realized the extent to which USP is involved in promoting the profession of pharmacy. I would like to thank the Board for nominating me to do this for our society."

- Stephen Eckel, PharmD, is Assistant Director of Pharmacy at UNC Hospitals in Chapel Hill.

WU Students Tackle Hot Health Topics

How to eat healthy, avoid stimulant abuse, diabetes, high cholesterol and tobacco use were hot topics addressed by Wingate University's pharmacy students in five community projects held in Union and Mecklenburg counties during the spring semester.

The students published a fast food survival guide to help illustrate the calories, fat and cholesterol in foods found in five of the most popular fast food chains. They took their presentation to Benton Heights Presbyterian Church's senior adult group to point out the health risks of fast food. Students Jameeka Carrington, Julie Hall, Ashley Helms, David Nguyen, Patrick Parkhurst and Daniel Ward presented the information then led the group in a game of cholesterol jeopardy.

Another group of students met with students at UNC-Charlotte to discuss the risks of overusing ADHD medications and weight loss drugs as stimulants. Such drugs are popular among students who are using them to stay awake while studying. Misuse can cause heart problems and other negative side effects. Conducting the project were pharmacy students Urundi Moore, Maria Tzefos, Christina Tucker, Jeff Malone, Erin Williams and Matthew Zappas.

The diabetes project led by Jenna Weissert, Shay Cox, Hollie Duplessis, Tammy Strange and Rama Al Ghannam focused on screening for adults over age 55. The group studied the prevalence of diabetes, the risks and need for education among seniors. They then interviewed and screened seniors at the local VFW and Senior Center in Monroe.

WU. students involved in the Cardiovascular project: Christine Farkas, Ashley Davis, Shane Crook, Lee Crocker, Anna Ginzburg, Cassie Efird

Another project addressed tobacco use in local high schools. With the assistance of two $3,000 mini grants from the TRU Foundation, the Wingate students were able to start tobacco use prevention clubs at two High Schools to educate students on the health risks of smoking. The group conducted a survey that revealed that 80 percent of students have a parent who smokes. The project also educated students about the risks of chewing tobacco and gave out sunflower seeds as an alternative. Wingate students Jennifer Calhoun, Emily Green, Josh Guffey, Andrea Hill, David Homka and Melanie Kay worked with the local high schools to start both clubs.

The final project centered on cardiovascular risk education for seniors and included high blood pressure and cholesterol screening at the Day of Dance event at Wingate University and at the Fitzgerald Center, Sanger Clinic and the Monroe Assisted Living Center. Participating students included Lee Crocker, Anna Ginzburg, Cassie Efird, Ashley Davis, Christine Farkas and Shane Crook. ❖

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Harold Wells, chairman of the Campbell University Board of Trustees, announced plans for a new pharmacy teaching facility and broke ground on the $9.9 million, 42,000-square foot facility on May 24. The new building will actually double the space contained in the school's current facility, allowing it to keep pace with the tremendous growth the School of Pharmacy has experienced since its founding in 1986.

"We are extremely proud of our pharmacy school record over the past 19 years," said Wells. "The new pharmacy building is a giant step in equipping our students for the future. It will enable our staff and faculty to maximize effective pharmaceutical education far into the future."

An architectural drawing of the new pharmacy teaching facility at Campbell University.

Dr. Ronald Maddox, dean of the School of Pharmacy, added that a new state-of-the-art facility is essential to Campbell's Pharmacy program. "We are at a critical juncture in our history in which the School of Pharmacy has evolved to the point that additional space is needed if we are to continue to offer one of the most reputable and successful programs in the nation," Maddox said. "With the addition of the new building, Campbell will provide students with exemplary teaching accommodations."

The School of Pharmacy has grown from 54 students in the 1986 charter class to over 600 students currently, including 409 Doctor of Pharmacy candidates, 127 students in Clinical Research, 99 students in Pharmaceutical Science and 361 students in the Pre-Pharmacy program. For the 2004 fall semester 1,210 students applied for 100 available places in the Doctor of Pharmacy program. The program also boasts a number of outstanding achievements, including an overall passage rate on board exams of 99 percent and a 100 percent passage rate on board exams nine out of the last 15 years. Competing against 90 other schools in the nation, Campbell's School of Pharmacy won the national Clinical Skills and Patient Counseling competitions twice.

Located between the Science Building and Carter Gymnasium, the new three-story facility will feature classrooms, a student study center, breakout rooms, administrative and alumni suites, two 3,534 square-foot lecture halls, faculty offices, a Professional Association room, and close to 6,000 square-feet of laboratory space, as well as a lab preparation area.

In 2001, the University also dedicated the Pharmacy Research Facility and is currently pursuing FDA certification for the facility. According to Maddox, the purpose of the Research Facility is two-fold: to train students in state-of-the art pharmaceutical manufacturing and to provide an opportunity for faculty to engage in research endeavors associated with the pharmaceutical industry.

"Though the new pharmacy teaching facility and the Research Facility, Campbell University will enhance its capability to train pharmacy students to meet current and future needs of our region and the nation," Maddox added. ❖

UNC'S BROUWER HONORED FOR PATENT

The US Patent and Trademark Office issued 26 patents in 2004 that were assigned to UNC, university officials recently announced.

"These patents, in turn, often are developed into products by companies partnering with the university, ensuring that Carolina research benefits the public through commercialization, where appropriate," said Mark Crowell, associate vice chancellor for economic development and technology transfer at UNC. The 25 current UNC inventors received a plaque - a replica in brass of the front page of their patents - at a special campus ceremony in May honoring their achievement. Among those receiving recognition for their 2004 patents was NCAP member Kim Brouwer, a professor in UNC's School of Pharmacy. She developed a method for using cultured cells to evaluate the susceptibility of drug candidates

to excretion by the liver. This technology has been licensed to Qualyst, founded in 2001 on breakthrough discoveries research conducted by Brouwer and two of her School of Pharmacy colleagues.

ECKEL RECEIVES U. OF THE SCIENCES ALUMNI AWARD

NCAP Executive Director Fred Eckel was presented an Alumni Award on May 7, 2005 from the University of the Sciences in Philadelphia. The award was presented for having contributed in outstanding fashion to the profession, to science and/or to mankind. Fred serves as executive director of the NC Center for Pharmaceutical Care, is editor of Pharmacy Times and has contributed to more than 200 articles and editorials. He grew up in Philadelphia, earned his MS degree from The Ohio State University School of Pharmacy, then completed a residency in hospital pharmacy. He served as Director of Pharmacy at UNC Hospitals from 1968 to 1975 and currently serves as assistant director for education and research and executive director of the residency program for the hospital. He is a past president of ASHP, NCSHP and has spoken at pharmacy meetings in 50 states and on five continents.

GLISSON FEATURED IN *AMERICA'S PHARMACIST*

Gary Glisson, owner of Ward Drug Company in Nashville and majority owner of Healthwise Pharmacy in Greenville, was featured in the May issue of *America's Pharmacist*. The article focused on how Glisson successfully markets two pharmacies that are 50 miles apart. Ward Drug has a mix of prescription, OTC products and gifts while Healthwise focuses more on professional pharmacy services and medical equipment sales.

LOCKAMY RECEIVES KEITH FEARING AWARD

When a major health care facility in Raleigh, NC closed its doors, Albert Lockamy, Jr., then president of the North Carolina Board of Pharmacy, spearheaded a regulation providing continuance of pharmacy care to over 60,000 patients. He also pushed to empower pharmacists to extend prescription drug coverage in emergency situations from six days to 30 days. As a result of his efforts, other states have used North Carolina as a model for advancing patient care in emergency situations.

Lockamy was honored Thursday, May 5, when he was presented the M. Keith Fearing Community Pharmacy Practice Award by the Campbell University School of Pharmacy.

"The Keith Fearing Award is based on individual contribution and community service," said Lib Fearing, the wife of the late Keith Fearing. "You've joined the ranks of a group of outstanding pharmacists who have served their profession well."

A native of Clinton, NC, Lockamy was a pharmacist with Revco Drugs for 27 years, remaining with the company when it was sold to CVS until his retirement six years later. After a brief retirement, Lockamy discovered that he missed the practice of pharmacy and signed on with Blue Ridge Pharmacy in Raleigh where he is currently employed.

Lockamy has served as president of the North Carolina Board of Pharmacy, the North Carolina Pharmaceutical Association and Wake Pharmaceutical Association. He was chairman of the North Carolina Pharmaceutical Association Endowment Foundation and appointed to a fourth term on the North Carolina Medical Care Commission. He also served as a member of the accreditation team of the American Council of Pharmacy Education.

Among his many honors, Lockamy was named National Pharmacist of the Year by Revco, Pharmacist of the Year by the North Carolina Pharmaceutical Association and "Tar Heel of the Week by the Raleigh "News & Observer." He was a Fellow of the American and North Carolina pharmaceutical associations and received the Distinguished Service Award from the University of North Carolina School of Pharmacy.

In addition, Lockamy has served Campbell University in a variety of ways-as a practitioner-instructor and as a member of the Presidential Board of Advisors and the School of Pharmacy's Admissions Advi-

Pharmacist Albert Lockamy, Jr. receives the M. Keith Fearing Community Pharmacy Practice Award from Campbell University's School of Pharmacy From left, Dr. Dwaine Greene, vice president for Academic Affairs and provost; Dr. Jerry M. Wallace, president of Campbell University; Al Lockamy; Mrs. Lib Fearing, widow of M. Keith Fearing, and Dr. Ronald Maddox, dean of the School of Pharmacy. (Photo by Bennett Scarborough)

sory Board. His articles have been published in Pfizer Guide: Pharmacy Career Opportunities, American Pharmacy, and The Carolina Journal of Pharmacy, among others.

"The Campbell University School of Pharmacy is pleased to have Al Lockamy for our students to emulate," said Dr. Ronald Maddox, dean of the School of Pharmacy. "He is an outstanding example of the type of individual that the M. Keith Fearing Community Pharmacy Practice Award is designed to recognize."

The M. Keith Fearing Community Pharmacy Practice award is given in memory of Keith Fearing, a 1941 alumnus of Campbell who was instrumental in the establishment of the Campbell University School of Pharmacy. The Fearing award was established in 1997 to honor Fearing's memory and his contributions to community pharmacy practice.

KERR IMPLEMENTS WEIGHT LOSS CENTERS

Medifast, Inc., a leading weight loss and weight management company, announced the launch of the first clinical weight loss centers in a regional chain drug store under a pharmacy program. Medifast's Hi-Energy Weight Control Centers officially opened their doors in two Kerr Drug stores in Greensboro and Raleigh, North Carolina

Since clinical pharmacy programs have a concentrated obese and diabetic patient base, the new Hi-Energy Weight Control Centers are well aligned with Kerr Drug's vision to offer its patients both pharmaceutical and nutritional support in the same location.

Bill Baxley, Executive VP of Kerr Drug said "This partnership with Hi-Energy demonstrates our continued commitment to advancing the concept of community pharmacy care by offering health and wellness services that exceed the traditional drug store mix."

Individuals needing on-site support in their effort to lose weight can now easily tap into the proper program right at their local drug store. Hi-Energy's participants will be guided and supported under Certified Weight Loss Counselors, and taught how to make lifestyle changes to lose weight and maintain it permanently.

TRAVEL OPPORTUNITIES FOR NCAP MEMBERS

NCAP will continue to work with Collette Vacations to sponsor travel for our members. So far we have sponsored trips to Italy, Ireland, Scotland, the Canadian Rockies, San Francisco/ Lake Tahoe, and a "Call of the Canyons" trip that toured canyons of the west, including the Grand Canyon. We plan to promote a group trip within the US and an international trip to Australia and New Zealand in 2006. However, we can assist you with group travel to any destination. We do all the planning, you just relax and enjoy your trip! Please contact Linda Goswick at NCAP, 800.852.7343 or e-mail linda@ncpharmacists.org.

DOOR PRIZES SOUGHT FOR CONVENTION

We will again have an Awards Banquet at the October 16-18 Annual Convention. If you and/ or your company are interested in donating a door prize this support would be appreciated. Contributors will be recognized in the Awards Banquet program. Contact Linda Goswick at 800.852.7343 or linda@ncpharmacists.org.

Calendar

For more information about NCAP events visit www.ncpharmacists.org or call NCAP at 919.967.2237.

Sept. 9: ***Pharmacy-Based Immunization Delivery Program***, Wilmington Hilton Riverside, Wilmington, NC. Be prepated to assist your patients with their immunization needs this fall. Call 919.966.1128 for more information.

Sept. 10-11: ***North Carolina Pharmacy Practice Seminar.*** Wilmington Hilton Riverside, Wilmington, NC. Visit www.pharmacy.unc.edu/continuing/onlinereg/ or call 919.966.1128.

Oct. 15-19: ***NCPA Annual Convention.*** Fort Lauderdale, FL. For more information visit www.ncpanet.org

Oct. 16: ***NCAP Entrepreneurial Pharmacy Practice Program.*** A special NCAP Convention program for pharmacy owners and future pharmacy owners. Reviews the key areas of financial management and break-even analysis. Learn to master the most practical financial tool available to pharmacy owners and managers.1:30 pm to 9:00 pm, Sheraton Imperial, Research Triangle Park, NC.

Oct. 16-18: ***NCAP Annual Convention.*** Sheraton Imperial, Research Triangle Park, NC. North Carolina's largest pharmacy meeting has something for all pharmacists. Don't miss this opportunity for quality CE programming, networking, exhibitor program, residency showcase, awards banquet and more! Check your mailbox for a brochure or visit the NCAP Web site.

Oct. 23-26: ***ACCP Annual Meeting.*** San Francisco, CA. More information at www.accp.com

Nov. 9-12: ***ASCP Annual Meeting.*** Boston, MA. For more information visit www.ascp.com

Dec. 4-8: ***ASHP Midyear Clinical Meeting.*** Las Vegas, NV. More information can be found at www.ashp.org

North Carolina
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Examining

Long-term Care

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North Carolina Pharmacist

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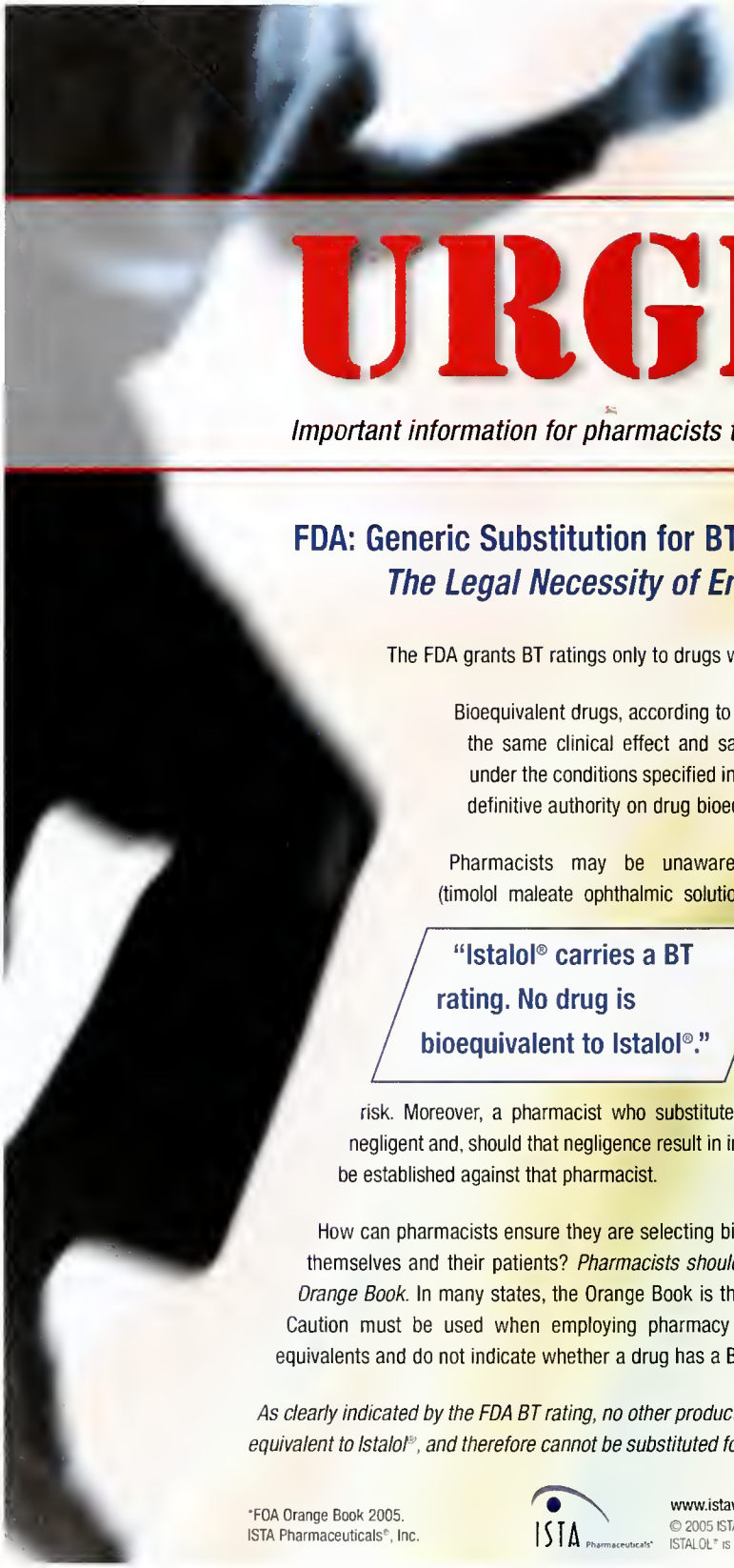

URGENT

Important information for pharmacists treating patients with glaucoma

FDA: Generic Substitution for BT-Rated Meds Carries Risk

The Legal Necessity of Ensuring Bioequivalence

The FDA grants BT ratings only to drugs with no recognized bioequivalent.

Bioequivalent drugs, according to the Orange Book, "can be expected to have the same clinical effect and safety profile when administered to patients under the conditions specified in the labeling." The Orange Book remains the definitive authority on drug bioequivalence.

Pharmacists may be unaware that ophthalmic beta-blocker Istalol® (timolol maleate ophthalmic solution) 0.5% carries a BT rating.* No drug is bioequivalent to Istalol®. *It may be illegal in your state to substitute BT-rated products.* Check pharmacy laws in your state. Such substitutions have the potential to place a pharmacist's professional license and personal assets at risk. Moreover, a pharmacist who substitutes a drug that is not bioequivalent may be negligent and, should that negligence result in injury to a patient, a legal cause of action may be established against that pharmacist.

"Istalol® carries a BT rating. No drug is bioequivalent to Istalol®."

How can pharmacists ensure they are selecting bioequivalent medications, thereby protecting themselves and their patients? *Pharmacists should refer to the FDA authoritative source, the Orange Book.* In many states, the Orange Book is the only official reference for bioequivalence. Caution must be used when employing pharmacy software programs that only list generic equivalents and do not indicate whether a drug has a BT rating.

As clearly indicated by the FDA BT rating, no other product, including generic timolol, is therapeutically equivalent to Istalol®, and therefore cannot be substituted for it. To do so may be a violation in your state.

*FOA Orange Book 2005.
ISTA Pharmaceuticals®, Inc.

ISTA Pharmaceuticals®

www.istavision.com

IT'S MEMBERSHIP RENEWAL TIME!

Now You Can Renew Your NCAP Membership Online

For those members who have not yet renewed their membership for 2006, please do so by Dec. 31. There are two ways to renew: you will receive a renewal notice in the mail that you can fill out and fax or mail back to us or you can renew your membership the easy way on our secure Web site at http://www.ncpharmacists.org/payduesmbrtype.cfm

You'll save time for yourself and for the NCAP staff!

You'll need to know your password to renew. If you don't remember it, just e-mail teressa@ncpharmacists.org or call us at 919-967-2237.

When you renew your membership please be sure to update all of your information. We don't want to lose touch with our members.


Fred Eckel

Crisis or Opportunity?

Pharmacy may be facing its biggest challenge or greatest opportunity in forty years. Medicare Part D will become operational January 1, 2006, and with it could come major changes. It was reported to me that one chain has told its pharmacists that hours may be cut next year because they anticipate a significant increase in mail-order prescriptions because Prescription Drug Plans (PDP) will promote this mechanism for patients to obtain their drugs. Even without a mail-order volume increase, many PDPs' dispensing fees are more similar to current PBM fees than the usual and customary charges paid by cash customers. Either of these scenarios will put even more pressure on the pharmacy's bottom line.

There are more people who see opportunity in the Medicare Part D Program. The Medication Therapy Management (MTM) program will pay pharmacists directly for cognitive services. Success with MTM in Medicare will encourage other payers to follow suit, they say. The increased prescription volume created by the availability of new payments for prescription drugs will increase prescription revenues and increase traffic in community pharmacies. Only time will tell who is right.

NCAP sees Medicare Part D as an opportunity for pharmacists to assist their patients in selecting an appropriate PDP. To that end we have conducted twelve regional training sessions and have already trained over 600 pharmacists. These programs were made possible by a grant from NC Senior Care. Additionally, we are a partner in the Medicare Education Coalition along with the North Carolina Medical Society and Pfizer (see excerpt of press release below). The Coalition has produced PSA's for radio and television and LaRue Dedrick is pharmacy's spokesperson. We had an exhibit at the Dixie Classic Fair and the NC State Fair. Consumer brochures were provided to all NC community pharmacies. I have been on several radio talk shows about the Medicare Part D Program. All our efforts are to inform consumers and pharmacists about Medicare Part D.

Congress is debating, as I write this column, a new formula to reimburse pharmacists for filling Medicaid prescriptions. The National Community Pharmacists Association stated that the proposed reimbursement formula could end up closing forty percent of community pharmacies. Again, time will tell what the formula is and what impact it will have on pharmacy as a profession. That we need to work together across all pharmacy settings seems evident and makes the role of NCAP even more strategic.

In my spiritual journey I learned that complacency is more common when things are going well. It is the difficulties of life that cause me to focus and get busy doing what I need to do. Perhaps these "bumps in the road" will wake up more pharmacists, get them professionally involved and, as a result, pharmacy will be stronger.

Finally, let me close with several comments about NCAP. Our Convention is now behind us. Over 650 individuals participated in some part of the Convention (almost four hundred pharmacists and over two hundred pharmacy students). The NC Chapter of the American Society of Consultant Pharmacists has merged with NCAP to become the Chronic Care Practice Forum. We now have three practice forums functioning and beginning in 2006 each will have a stand-alone spring meeting:

- Community Care Practice Forum March 5-6
- Chronic Care Practice Forum March 23-24
- Acute Care Practice Forum April 24-26

Through the first nine months of 2005 our income is $397,479.09, and expenses are $359,316.06 for a change in net assets of $38,163.03. Our total assets are $415,672.49.

The remodeling of our home, the Institute of Pharmacy, is almost complete. Come by and see us. We are planning an Open House in the spring to show off our facility. ❖

NCAP Joins North Carolina Medicare Education Coalition

The North Carolina Association of Pharmacists has joined with the North Carolina Medical Society and Pfizer to form the North Carolina Medicare Education Coalition (NCMEC). The purpose of the group is to provide important information to North Carolina's current and future Medicare beneficiaries about the upcoming changes in Medicare, which will offer a prescription drug benefit for the first time.

Research recently released by the Kaiser Foundation shows that more than two-thirds of seniors (ages 65+) describe their level of understanding of the Medicare benefit as either "not too well" or "not well at all," and 40 percent have not heard enough to decide if it is right for them. The same study indicates 45 percent of seniors do not realize they must enroll in a plan to receive benefits.

NCMEC has been conducting outreach to seniors across North Carolina to help provide Medicare information. Efforts have included public service announcements, educational booths at pharmacies, fairs and other locations and outreach through the news media. In addition to educating seniors directly, the group has provided educational materials to physicians and pharmacists to help them become more knowledgeable about Medicare changes.

NCAP mailed educational brochures to every pharmacy in the state and hosted educational booths at pharmacies in seven major cities. Pharmacist LaRue Dedrick auditioned and taped a thirty second public service announcement that is being broadcast on several television stations.

"Over the coming months there will be a lot of discussion about Medicare," said Fred Eckel, executive director of the North Carolina Association of Pharmacists. "We know seniors will turn to their pharmacists and physicians for help understanding the prescription drug benefit, so it is important the NCMEC helps provide that information."

North Carolina Association of Pharmacists
109 Church Street
Chapel Hill, NC 27516
phone: 919 967 2237 • fax 919 968 9430


Davie Waggett

Dear NCAP Members,

Well, it's already November 2005, and once again I am reminded that I can't slow down the clock. My NCAP term as your president will soon come to an end, yet NCAP's work will go on. We still have much to do this year though, with committee appointments and next year's budget to finalize and put into action.

At the beginning of the 2005 term in January we strived to work on things that we could affect and to try to make the year's agenda list not be too long to manage. To recap, we decided on four (4) major initiatives to concentrate on, and to put those four initiatives into action. The four items identified were 1) to promote patient care initiatives that would improve patient outcomes, 2) to reactivate the practice forums for each major practice setting of pharmacy, 3) to establish, promote, and enhance our relationship with the NC Board of Pharmacy, and 4) to continue leadership activities for pharmacists and pharmacy students. As always, we would address membership, or lack of membership, and we devoted an extra Board day to try and enhance our membership services and ultimately, our numbers.

In most of these areas NCAP was very successful in getting things started, reactivated, enhanced, and continued. Groundwork was put into place so that future leadership can carry this work on as it will need to always be evaluated and fine-tuned each year. One of the practice forums, the Chronic or Long-term Care Practice Forum, is in the process of being reformed, and we expect to see good things occur in 2006. And as always, membership numbers are an issue. It just seems that to many, membership in a State organization is not necessary or wanted. There are so many things that NCAP handles for the profession of Pharmacy, that I shudder to think of exactly who would do these things if NCAP didn't. Even when we publish the long list of things accomplished in a year, the rank and file seem to just ignore the facts and remain inactive. I hope that the tide will soon turn and that a wave of support will soon flow into our only professional state organization.

All in all, it has been a very rewarding and informative year for me as your president. There are so many positive things going on in North Carolina in the field of Pharmacy, and many states look to us for innovative practice ideas. There are many hardworking individuals who are working on cutting-edge thinking in our practice, and who will be leaders in the future. We must, as an entire profession, support and embrace the progress that is being made, and at the same time, we must not forget what has gotten us this far. Pharmacy is a great profession. I love the many opportunities that we have every day to be one-on-one with our patients and help them improve their medication outcomes. We must not forget or lose site of what we are here for... to serve those who need what we can provide.

I wish to thank all those who have supported me this year, in thought and in hands-on work. I want to thank the entire NCAP staff for supporting me this year and for keeping me on track and handling lots of behind the scene activities and functions. They are a very hard-working crew.

The year 2006 will be a most challenging one for Pharmacy. Let us all support each other, be proactive, and meet this coming year with a positive and helping attitude. Pharmacy IS a great profession!

Thanks,
Davie Waggett, RPh
President

...applying drug knowledge to improve health

Examining Long-term Care

Getting Involved to Improve Patient Care

NCAP's Chronic Care Practice Forum represents a specialized group of pharmacy practitioners serving a very unique and very special patient population in our State. Chronic Care pharmacists provide patient care in a variety of settings including nursing homes, retirement communities, rehabilitation centers, homes for the mentally handicapped, children's homes, hospice organizations, home care, physician offices, and even prisons. Chronic Care pharmacists serve patient populations that are not only diverse, but serve patients in our society who have very special needs for comprehensive pharmaceutical care.

Chronic Care patients, be it from the effects of aging, mental illness, or disabilities, often cannot care for themselves and thus, depend solely upon their pharmacist to assure safe and appropriate pharmaceutical care. For many of these patients, our decisions as clinicians not only serve to improve the quality of life, but also serve to help these patients lead more fruitful and productive lives. Through our practices serving patients in the many settings listed above, Chronic Care pharmacists contribute to the treatment of virtually every condition and disease state in patients of all ages.

Chronic Care pharmacy practice is growing at an incredible rate. With the first of the Baby Boom generation beginning to reach retirement age, and these numbers peaking within the next 12 years, Chronic Care pharmacy will see tremendous growth opportunities in all settings. Many growth opportunities will also evolve as the pharmaceutical care model for the Chronic Care population diversifies to meet the needs of an ever changing and more complex patient population, and due to changes in the regulatory environment which will shape how future pharmacy care is delivered to this segment of our population.

As our professional opportunities grow, the Chronic Care Practice Forum of NCAP is also growing and evolving to better meet the needs of our highly diversified membership. With the recent consolidation of North Carolina's ASCP Chapter into NCAP's Chronic Care Practice Forum, the Forum will now be able provide a consistent and focused effort in support of all pharmacy disciplines serving Chronic Care patients. Current membership in the Chronic Care Practice Forum stands at 311 members out of 2,583 NCAP members, and 8,184 pharmacists actively practicing in our state. We know there are many more pharmacists in our state providing pharmaceutical care to the Chronic Care patient population, and we extend an invitation to each of you to get involved, join NCAP, and become active in the Chronic Care Forum, or one of the other NCAP Practice Forums. There has never been a more important time to get involved with your state pharmacy association, to promote our profession, and to keep up with the changing models of pharmacy practice that are evolving in our state and country.

Within this article, you will hear from members of the Chronic Care Practice Forum as they describe their unique areas of practice, opportunities that exist for pharmacists in this growing market, and how the Forum has worked legislatively at State and Federal levels to meet the needs of our patients and promote our unique areas of practice. Our members represent not only excellent pharmacists and clinicians, but also some amazing entrepreneurs who have developed unique businesses to provide pharmaceutical care to a special patient population.

Jessica Visco, PharmD, CGP counsels a long-time participant in the Senior Pharm*Assist* program.

If you are serving patients in the Chronic Care setting, or serving patients' pharmacy needs in other unique practice settings, please consider joining NCAP and the Chronic Care Forum. Our industry, and our Practice Forum are going through significant change and growth, and your participation will be welcomed and appreciated.

Rick Whitesell
Medipack Pharmacy,
Charlotte, NC
Chair, NCAP Chronic Care Practice Forum

Business Opportunities

McNeill's Long Term Care Pharmacy is a division of Liberty Health Care Services, Inc., one of North Carolina's largest and most comprehensive privately owned health care companies. The company owns and operates nursing homes, assisted living centers, home care agencies, hospice agencies, durable medical supply offices, outpatient infusion agencies and a long-term care pharmacy. The McNeill family is in its fourth generation of practicing pharmacists and also operates the oldest retail pharmacy in North Carolina, located in Whiteville.

The McNeill family has strategically positioned itself to provide health care services to the most rapidly expanding sector of the health care market. The aging Baby Boomer population has resulted in a phenomenon known as "The Graying of America" which essentially refers to the increase in the average age of the general

population due to the aging Baby Boomers. The Baby Boomers have forced changes in various markets since the 1950's. The health care market in the 21st century is now facing challenges brought about by the Baby Boomers, specifically how to provide health care to an expanded market with continually decreasing health care resources. The most critical shortage in health care resources is in health care workers such as pharmacists and nurses, as well as a shortage in available health care funds to pay for the escalating cost of health care services.

As manager of McNeill's Long Term Care Pharmacy I have chosen to confront these challenges aggressively by embracing new and emerging technologies, such as automation, to increase operational efficiency and reduce the impact of fluctuations or shortages in the available technical and professional workforce. Changing reimbursement models, such as Medicare Part D, have introduced the most challenging financial obstacles to overcome in pharmacy. This is particularly true in the long-term care market where greater than 80 percent of patients will move from a single payer source now, to multiple payer sources on January 1, 2006, all having different cost structures, fee structures, formularies and operational procedures. Changing reimbursement models directly impact cash flow by reducing operating margins and disrupting established business cycles. To hedge against the risks arising from interruptions in cash flow, operational efficiency must be maintained in areas such as inventory management and accounts receivable management. Increasing inventory turns and reducing the amount of days in accounts receivable improves cash flow. The marketplace also experiences challenges from regulatory agencies that most often result in increased expenses without offering opportunities to recoup lost revenues. The introduction of HIPAA taught owners and operators of health care companies that survival in the increasingly competitive environment was dependent on flexibility and the ability to respond quickly to changes in supply, demand and/or regulatory requirements.

The pharmacists who work for McNeill's Long Term Care Pharmacy can choose between a dispensing role, a consultant role or a combination of the two. This allows us to attract professionals with different interests and professional or career goals. Regardless of the career path, our mission is the same—to improve the quality of life for long-term care patients through the delivery of quality pharmaceutical products and services. The rewards that my pharmacists receive are personal and professional enrichment that is obtained through working in a diverse and flexible setting. Flexible scheduling allows pharmacists to fulfill family and personal goals and pursuits. Many pharmacists find that the long-term care setting allows them to become a more active and influential participant in the patient's health care team which is professionally rewarding.

The practice of pharmacy is much different than it was thirty years ago when the career options consisted primarily of retail or hospital positions. I recommend that pharmacists, and particularly students, expose themselves to as many different practice settings as possible to help them discover the niche that best suits their professional goals and interests. They may find, as I have, that long-term care is the emerging market leader.

John Watson, Manager
McNeill's Long Term Care Pharmacy
Whiteville, NC

Hands-On Assistance to Keep Seniors Healthy

Senior PHARM*Assist* opened its doors to the Durham community in June 1994, with the goal of helping seniors - particularly those with limited incomes - improve two medication issues: affordability and medication appropriateness. Nearly twelve years later, our focus remains the same.

From its inception, our program has promoted user-friendly access to needed medicines at community pharmacies via PNNC/Catalyst Rx, coupled with regular, required medication therapy management. Senior PHARM*Assist* covers medicines (minus an $8 co-pay) on our geriatric formulary, and our staff pharmacists see participants either in our office or the participants' homes every six months. Underpinning this effort has been our close collaboration with prescribers, community pharmacists, and seniors to ensure that everyone is on the same "medication page."

Over the years, we have learned that additional services, such as community referral to other valuable resources, e.g., home-delivered meals, medical transportation, etc., offer a vital complement to our focus on pharmaceutical care. Published evaluation outcomes have demonstrated that participants in our program report significant, sustained reductions in hospital admissions and emergency department use. We ascribe those positive results to our comprehensive approach to pharmaceutical care for seniors.

The stated mission of Senior PHARM*Assist* is to promote healthier living for Durham seniors by helping them obtain and better manage needed medications and by providing health education, community referral, and advocacy. We endeavor to provide seniors with the assistance and information they need to become wiser consumers and active participants in the maintenance of their own well-being. Our goal, simply put, is to help older adults remain as healthy and independent as long as possible.

Senior PHARM*Assist* has always stressed the importance of providing participants with respectful, highly tailored, hands-on assistance. This commitment has allowed us to build a rapport with those we serve; indeed, the very first participant to join our program is still enrolled today! Durham seniors have learned they can trust our staff for reliable information and one-on-one help with their medication needs. And that trust has never been more important than it is today.

While the prescription assistance landscape has changed dramatically over the past decade, nothing compares to the "seismic shift" now occurring with Medicare. Throughout the nation, older adults are overwhelmed by the prospect of selecting a Medicare prescription drug plan. In North Carolina, they will choose from among 53 privately administered plans (38 are stand alone PDPs). What's more, many seniors are struggling to determine whether they can afford to pay for this new benefit, even as current sources of pharmaceutical assistance - such as NC Senior Care and the drug manufacturer's patient assistance programs - begin to dry up. Medicare beneficiaries need hands-on help.

In Durham, Senior PHARM*Assist* is partnering with representatives from the Seniors' Health Insurance Information Program (SHIIP), among others, to help seniors learn about and benefit from the changes to Medicare - to the greatest extent possible. We are now helping Durham seniors select the prescription plans that best suit their medication needs. This is a daunting task as numerous formularies, and other "utilization management tools" (prior authorization, step therapy and quantity limits) are creating unimaginable challenges for even the Medi-

care beneficiary with the highest health literacy skills.

For many with limited resources, accessing the Medicare drug benefit is a two-step process: 1) applying for a subsidy; and 2) picking a drug plan. For several months, our staff has been helping those who are eligible apply for Medicare drug plan subsidies so they could afford to enroll in a Medicare drug plan. To qualify for this "extra help" or government subsidy, seniors must have incomes at or below 150% of the federal poverty level (a gross annual income of $14,595/individual with less than $11,500 in liquid assets or $19,725/couple with less than $23,000 in liquid assets). Medicare beneficiaries who already have full Medicaid or a Medicare Savings Plan (state pays their Medicare Part B premium) automatically qualify for the prescription drug subsidy and do not need to complete an application.

At Senior PHARM*Assist*, we have great concern that those just above the subsidy cutoff - and even those between 135% to 150% of the FPL, who will only receive a partial subsidy - will struggle to participate in the Medicare prescription drug plans. Thus, our program is advocating that North Carolina provide "wraparound" funding to the new benefit. We have crafted a plan that essentially reinvents NC Senior Care and builds on the existing strengths of community programming in North Carolina, while underscoring the importance of medication therapy management. Our proposal has been endorsed by the NC Association of Pharmacists, the NC Association of Free Clinics, and NC Citizens for Public Health.

Our overriding contention is two-fold:

1. Thousands of Medicare beneficiaries cannot afford the cost-sharing structures as they are currently designed by Medicare

2. And the combination of increased access to medications and medication therapy management means that federal and state tax dollars will be saved as Medicare beneficiaries are healthier and less likely to be hospitalized, visit emergency departments, or need nursing or adult care home placement. The necessity for "wraparound" also acknowledges that many of our current "usual ways of helping," e.g., NC Senior Care, drug company discount cards and patient assistance programs, will evaporate in 2006.

Medicare beneficiaries are going to need "hands on" assistance to enroll in the Medicare prescription subsidy, pick a private drug plan that best suits their needs, and manage the barriers to obtaining medications they are likely to encounter. In addition, many Medicare beneficiaries who enroll in Medicare drug plans are going to need help maximizing/stretching their prescription drug benefit so they do not reach the coverage gap (called the doughnut hole) that some plans have.

All of the staff at Senior PHARM*Assist* will be very busy over the next few months and we know you will be too. In fact, we know that retail pharmacists will feel the "brunt" of the Medicare changes. We want to help alleviate some of that burden, but we need others to join us in our effort to tell our state officials that Medicare drug benefits, as they are currently designed, are not good enough for the people of North Carolina.

A few months back, one of our participants remarked: "I've read over the Medicare changes and don't believe that John and I will be able to afford the monthly premiums. We're counting on Senior PHARM*Assist* to help us figure out what to do when that time comes." We have an opportunity to not only help that senior and her husband, but between 115,000 to 130,000 Medicare beneficiaries across the state. To learn more about the proposal to "wraparound" the Medicare beneficiaries in North Carolina, you can visit www.seniorpharmassist.org or NCAP's Web site at www.ncpharmacists.org.

Gina Upchurch, RPh, MPH
Executive Director
Senior PHARM*Assist*
Durham, NC

LTC Practice From A Student Perspective

I am a final year (PY4) student at UNC Chapel Hill School of Pharmacy. Currently I am doing my monthly clinical rotations at different pharmacy sites in Wake County. My rotations so far has included nuclear pharmacy rotation at UNC Chapel Hill (August 2005), administrative rotation at NCAP in Chapel Hill (September 2005), and long-term care pharmacy rotation at Mast Pharmacy in Henderson (October 2005).

Prior to my current rotation, I had minimal awareness of the important roles a pharmacist can play in the long-term care setting. My prior knowledge of pharmacy careers was that pharmacists are prepared to either work in hospitals as clinical or staff pharmacists, in industries, in retail or independent pharmacies, or in the academic setting. I am quite sure that like me, many students have minimal knowledge of other roles which pharmacists play in the communities, particularly in the long-term care settings.

To appreciate the roles of long-term care pharmacists, one must understand the pharmacy practice types that fall under this discipline. These include mental health pharmacy practice, consultant pharmacy practice and many other practices that allow pharmacists to provide pharmaceutical care services to patients on long-term (chronic) bases. Just like the clinical pharmacists in the hospital pharmacy settings, long-term care pharmacists provide therapeutic drug monitoring services and management of the medication therapies of patients with chronic diseases who reside in long-term care facilities such as prisons, psychiatric facilities, group homes, assisted living facilities, nursing homes, etc.

Mast Pharmacy, my current rotation site, is an example of the pharmacies that provide long-term care pharmacy services. This pharmacy, owned by William Mast, not only supplies medications to the long-term care facilities that it serves, it also contracts with these facilities to provide them with pharmaceutical care services as required by the regulations governing long-term care.

During my visits to some of Mast Pharmacy's contracting facilities with my preceptor, Susan Cornett, we perform chart reviews, assess patients' therapies, and ensure that patients are treated according to the practice guidelines. We also ensure that there are no problems such as medication contraindications, adverse drug events, drug-drug interactions, and drug-food interactions. We communicate with the patients' primary care physicians regarding any conflicts or problems with the patient's therapeutic regimen and when appropriate, we recommend solutions. We also inspect the facilities' medication carts to ensure compliance with the required regulations; for instance we, check medication containers for expiration dates and check the controlled substance supplies for accuracy. In addition, we assess medication administration records to ensure that physicians' orders are transcribed appropriately and that patients are medicated according to the physicians' orders. Furthermore, we answer drug information questions that patients, medication administration personnel, and patient care givers may have. I am so pleased with the opportunity to be exposed to the long-term care

pharmacy practice. I urge students to consider rotations in this unique area of pharmacy.

Students who have interests in long-term care pharmacy practices should start early in their school years to make inquiries about the routes that would make their dreams possible. With close analysis, one can observe that the drugs and the disease states managements mostly emphasized in the current PharmD curriculum such as pharmacokinetics, hypertension, CVA, diabetes mellitus, heart diseases, kidney diseases, Alzheimer's disease, Parkinson's diseases, to mention but a few, mainly target patients with chronic diseases. In other words, the training received under the current PharmD curriculum is enough preparation for practice in a long-term care pharmacy setting.

However, students who want to be experts in this setting may want to get further certifications such as certified geriatric specialist (CGS) certification. Some students may also want to pursue residency in this field. As a student, one can become a member of the North Carolina Association of Pharmacists and participate in the Chronic Care Practice Forum meetings. At these meetings, long-term care pharmacists network and discuss issues facing long-term care pharmacy practices. Those who are particularly interested in the consultant pharmacy practice within long-term care pharmacy can become members of the American Society of Consultant Pharmacists (ASCP).

Calista Chukwu
PharmD Candidate, Class of 2006
UNC-Chapel Hill School of Pharmacy

Working Together to Create a Bright Future

My Reflection

In 1961 I went to The Ohio State University to study hospital pharmacy. My mentor, Clifton Latiolais, suggested that the role of the pharmacist in the nursing home environment was a good topic to explore for my MS thesis. Little did I know that the initial study published in the APhA Journal would launch my career in pharmacy and be an important contribution to the establishment of a new field of pharmacy.

In 1963 I served as Chair of the ASHPs Committee on Pharmacy Service to Small Hospitals and Nursing Homes. We started a trainingship program that enabled interested pharmacists, mostly from community practice, to do a structured training in hospital pharmacies to learn about institutional pharmacy practices, with the anticipation that they would gain both the skills set and the competence to begin offering services to small hospitals and nursing homes. The opportunity to offer these services was accelerated by the Medicare program in 1966. The Conditions for Participation for Hospitals required that the Medicare participating hospitals needed a pharmacist supervising the pharmacy program. The requirement helped launch a significant growth in hospital pharmacy.

George Archaubault, a pharmacy leader in the Public Health Service, was able to include in the Conditions of Participation for Nursing Homes in the new Medicare program, the need for each nursing home to have a consultant pharmacist. This new opportunity for pharmacists soon led to the formation of the American Society of Consultant Pharmacists (ASCP). ASCP guided the development of this field, eventually creating a new specialty, the Certified Geriatric Pharmacist.

The Plan of Pharmacy Assistance (POPA) drew me to North Carolina in the summer of 1966. This Duke Endowment and Z. Smith Reynolds Foundation supported program, started by the North Carolina Board of Pharmacy's Executive Director H.C. McAllister, was to assist North Carolina hospitals to develop pharmacy services under the control of pharmacists. In 1967 a second grant enabled us to expand POPA to nursing homes, and a third grant allowed us to focus on rest homes.

The next 35 years saw hospital and nursing home pharmacy practice opportunities explode. In 1999 North Carolina Pharmacy leaders saw changes on the horizon. They felt that North Carolina pharmacy could best be served by a single professional organization. In 2005 that goal became a reality when the NCASCP agreed to complete the merger process and become the NCAP Chronic Care Practice Forum (CCPF). Now it is my responsibility as Executive Director of NCAP to demonstrate that the CCPF will serve the needs of pharmacists practicing in nursing homes. At the same time, we need to find ways to use the expertise of these members to help prepare other pharmacists to better care for the unique needs of geriatric patients in all practice settings. This is a daunting task but North Carolina pharmacists have demonstrated their ability to solve complex problems while still working together to advance the profession.

My Dream

The newly enacted Medicare Part D program has brought new challenges and opportunities for pharmacists taking care of geriatric patients. Many of you could cite the initial problems trying to get patients enrolled in Medicare Part D. Geriatric patients need more than just obtaining access to drug coverage. They need help making the best use of their medications. That means the need for medication therapy management (MTM). Consultant pharmacists have been doing this in nursing homes. Medicare Part D should open up the opportunity to offer these services to more ambulatory patients through community pharmacists. Perhaps through NCAP we can find mechanisms for our Chronic Care Practice Forum and our Community Care Practice Forum to work together to make this happen. Could the traineeship model we implemented 45 years ago to develop hospital and nursing home pharmacy be used now to develop community pharmacy's new role under Medicare Part D? Could government regulations stimulate changes in community pharmacy practice like the Medicare Conditions of Participation changed hospital and nursing home practice? Could the requirement to pay for MTM under Medicare Part D slowly grow into a new revenue stream in community pharmacy for cognitive services? Could the recent graduates of community pharmacy residencies become the change agents to lead this revitalization in community pharmacy, just like residency trained hospital pharmacists facilitated the growth in hospital pharmacy? In ten years could we look back and see all the changes that occurred in pharmacy practice and realize that the opportunities that were created, and the innovative pharmacists who seized them, were the underpinning for the advancement of community pharmacy as an appreciated and respected part of the health care team? I don't know if it will happen but this dream is possible if we take advantage of the opportunities today. Consultant pharmacy will change too but I am counting on them to help NCAP and pharmacy transition to a bright new future that will benefit many geriatric patients.

Fred Eckel, RPh
Executive Director
North Carolina Association of Pharmacists

2005 NCAP Annual Convention

Outstanding Pharmacists Recognized at Awards Banquet

Over 650 pharmacy professionals attended the 2005 NCAP Convention held October 16-18 at the Sheraton Imperial Hotel in RTP, NC. More than 70 exhibitors filled the ballroom and a large and successful Residency Showcase was held. On Monday evening the Awards Banquet brought some of the brightest, most innovative pharmacists in North Carolina together. Banquet events included the presentation of awards, a buffet dinner and forty door prizes given away to the 109 people in attendance.

Rep. W.A. (Winkie) Wilkins receives the NCAP Presidential Award from Executive Director Fred Eckel.

Davie Waggett addresses the audience after receiving the NCAP President's Award in appreciation for his service as President of the Association.

Ron Stoll presents the Pharmacists Mutual Companies Distinguished Young Pharmacist Award to Stehphen Eckel.

Dave Moody receives the Don Blanton Award, for his contributions to the advancement of pharmacy in North Carolina, from Davie Waggett.

Rebecca Chater addresses the audience after receiving the Elan Biopharmaceuticals Innovative Pharmacy Practice Award.

The Fifty Plus Club honors members who have served as a licensed pharmacist for fifty years. Those in attendance for the ceremony were Eugene Walden Hackney, William Crane Griffin, Ralph Hilliard Ashworth, Jonnathan Adoneran Hill, Sr., and Evan Sylvanus Setzer, Jr.

David Work receives the Wyeth Pharmaceuticals Bowl of Hygiea Award from LeeAnna Hoskins.

Get Ready for the 2006 Meetings: *Community Care Practic*
Acute Care Practice Forum, April 24-26 • Pharmacy Prac

Dennis Williams receives the McKesson Leadership Award from Davie Waggett. Dennis also received the National Community Pharmacists Association Pharmacy Leadership Award.

2006 NCAP officers present for their installation were Dennis Williams, President, Leigh Foushee, Chair of the Community Care Practice Forum, and Eric Locklear, Chair of the Acute Care Practice Forum.

Another lucky winner! More than 40 door prizes were given away to the 109 Awards Banquet attendees.

Kim Leadon (left) presents the UNC School of Pharmacy Preceptor of the Year Award to Mary Parker, PharmD, BCPS, CPP.

Tina Bullard, CGP, (left) receives the Campbell University Preceptor of the Year Award from Valerie Clinard.

erum, March 5-6 • Chronic Care Practice Forum, March 23-24
c: Seminar, Sept. 8-10 • NCAP Annual Convention, Oct. 22-24

"Thank You" to the 2005 NCAP Convention Sponsors

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Pharmacists and students enjoy the buffet during exhibits.

A large crowd gathered for the Monday afternoon Residency Showcase in a hall filled with more than 70 exhibitors.

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The Pharmacist Refresher course is designed for pharmacists who wish to return to community pharmacy practice after an absence from practice for three or more years. The course consists of three modules, all of which have been approved for American Council on Pharmaceutical Education (ACPE) continuing education credits. The first two modules are completely online and composed of weekly study segments that allow course participants to work at their own pace, on their own time. The third module consists of a three-week, 90-hour 'live' experience in a community pharmacy. The Connecticut Pharmacy Association (CPA) will assist in sourcing pharmacies at which participants can complete the module. Only those who participate in all three modules will earn a Pharmacist Refresher Course Certificate from Charter Oak State College. Those taking modules One and/or Two for personal enrichment will earn ACPE credits through CPA.

The North Carolina Association of Pharmacists has partnered with the CT Pharmacists Association to offer you this online refresher course.

To find out more about the Pharmacist Refresher course call Charter Oak's Distance Learning Office at (860) 832-3837 or (860) 832-3812 or visit http://www.cosc.edu/distancelearning/noncredit.cfm. For additional information about course content, contact the Connecticut Pharmacists Association at (860) 563-4619.

Pharmacy Quality Assurance Protection Act

by John M. Kessler

Only time will tell, but August 24, 2005 may be remembered as one of the more important dates for patient safety in North Carolina. In a Bill supported by NCAP and other Pharmacy organizations in the State, the General Assembly ratified the Pharmacy Quality Assurance Protection Act (HB 1493). This Act establishes a mechanism to facilitate the continuous review of the practice of pharmacy. More specifically, the legislation's intent is to enhance the quality of health care and reduce medication errors.

The Requirements

Effective January 1, 2006, all pharmacy permit holders in North Carolina are required to participate in a quality assurance program and evaluate the following:

(1) The quality of the practice of pharmacy.
(2) The cause of alleged medication errors and incidents.
(3) Pharmaceutical care outcomes.
(4) Possible improvements for the practice of pharmacy.
(5) Methods to reduce alleged medication errors and incidents.

The essence of the Act and possibly its most valuable contribution is the newly afforded protections from legal and public discovery of quality assurance data, including reports and investigations of medication errors and incidents. Medication errors in hospitals have been generally protected from legal discovery for many years. These protections derived from quality assurance peer review programs established for physicians and hospitals. In marked contrast, the majority of pharmacists in nursing home practices, home care entities, ambulatory care and retail practices have not practiced under statutory peer review protections. The practical thinking has been - why should I report errors, potential errors or quality problems, if my reports can be subpoened by courts and regulators for punitive actions? Inarguably, the lack of statutory peer review/quality assurance protections has inhibited the reporting of quality problems, medication errors and potential medication errors. While the overall underreporting of quality problems and errors is a multifactorial problem, this Act removes one more significant barrier to reporting errors and discovering the root causes of error. My belief is that pharmacists will come to realize the benefits of exposing the root causes of errors within the protections afforded by an effective and non-punitive quality assurance program. I expect that this realization will occur slowly and cautiously as the benefits of the improvement actions are being demonstrated.

Quality of Care and Outcomes

Improved workflow programs, automation, bar coding, standardization, and other initiatives continue to reduce the likelihood and frequency of dispensing errors. In a recent discussion with a pharmacist colleague, I was impressed that over the last 2 years he has had no known dispensing errors in his store after a workflow improvement program had been instituted. The Act, however, addresses quality from more than just the perspective of dispensing errors and potential errors. It establishes the requirement for every pharmacy to participate in a program that assures the quality of practice and improves the quality of pharmaceutical care outcomes.

Ultimately, it will be up to the profession to determine exactly how the Act will affect Pharmacy in North Carolina. The specifics of the changes are not defined in the law. As food for thought, I can imagine that pharmacies might begin to look for quality metrics in their disease management programs. What percentage of patients with hypertension are at goal BP's? What percentage of patients with diabetes have their HbA1c's at goal? What percentage of patients with elevated lipids are within NCEP standards? What percentage of patients are adherent to their medication refill schedules? In other situations, pharmacies might look at their DUR programs and retrospectively evaluate how well drug interaction alerts and other computer generated messages were managed. Some pharmacies may begin to document their drug information questions and later review these for accuracy and completeness. Other pharmacies may survey their use of safe medication practices and make comparisons to guidelines in the literature. Quality is often assessed from the customer's perspective, so it is reasonable to imagine a program that collects data from customers and analyzes the results for improvement opportunities. The list of possible metrics and areas of quality review are endless.

Other Features and Requirements

In brief, the Act requires the pharmacy manager to compile and provide documentation of any serious alleged medication error or incident committed by the pharmacist in the preceeding 12 months, including events that result in visits to a physician or an emergency room, hospitalization requiring an overnight stay or longer or a fatality. The Act specifies that the pharmacy manager may designate an agent to handle these notifications, data retrieval and investigations. While requiring reports of previous severe medication errors, the documentation provided to the Board will not include the proceedings and records of a pharmacy quality assurance program or information prepared by the pharmacy solely for consideration by or upon request of a pharmacy quality assurance program.

There are many operational details and choices that remain undefined. I am confident that "best practices" will emerge from individual pharmacy initiatives and the collective wisdom of all practitioners and leaders at NCAP will provide the solutions. The spirit of the statute is to improve the quality of care and pharmacy outcomes. This is a great time for Pharmacy in North Carolina and for the citizens of this State. ❖

About the Author...
John M. Kessler, PharmD, BCPS is Chief Clinical Officer of SecandStory Health, LLC. He can be reached at jkessler@secandstaryhealth.com

Transition Now Underway

NABP Number to be Replaced by May, 2007

The National Council for Prescription Drug Programs is preparing to aid pharmacies in obtaining their National Provider Identifier (NPI). NCPDP is also enhancing their Pharmacy Database to support the NPI and industry requested concepts.

The NPI is a unique identification number for healthcare providers that must be used by all HIPAA covered entities including pharmacies by May 23, 2007. Healthcare providers and all health plans and clearinghouses must use NPIs in the transactions specified by HIPAA.

"NCPDP has been enumerating pharmacies with NCPDP Provider ID Numbers since 1981," stated Lee Ann Stember, President of NCPDP. "With a proven pharmacy database and processes already in place, it is natural for NCPDP to take on this role on behalf of authorizing pharmacies."

The NCPDP Provider ID Number, formerly known as the NABP Number, is currently housed in a database that contains over 70,000 pharmacies and is used by the industry for claims processing, affiliating pharmacies with parent organizations, direct mailings, product recalls, network development, health plan directories and rebate information.

NCPDP is working with the pharmacy services sector of the healthcare industry to develop a "transition plan" for the pharmacy industry to obtain, test and use pharmacy NPIs over the next eighteen months. The transition plan and timeline are critical so that pharmacies and payers are in lock-step when transitioning from the NCPDP Provider ID Number currently used to the NPI, thus avoiding rejected claims and disruption in payment.

NCPDP is asking pharmacies to complete a non-binding pledge of their support for NCPDP's electronic file interchange (EFI) initiative. Pledging support will insure NCPDP will keep you updated on NCPDP's progress toward becoming an EFI Submitter. As of October 1st, NCPDP had obtained pledges on behalf of over 40,000 pharmacies including all large chains, the Department of Defense (DoD), Epic Pharmacy Network, McKesson, Indian Health Service, AmerisourceBergen, United Drugs, as well as numerous medium and small chains and independents.

NCPDP will require additional information from pharmacies to apply for their NPI number, including taxonomy codes and other identifiers. However, there will be no additional cost to pharmacies for EFI services provided by the Council. The only cost involved is the current cost of $100 for enumerating new pharmacies or those pharmacies that change ownership. The paper application is available at http://www.ncpdp.org/PDF/092005_Pharmacy_Form.PDF

For more information about NCPDP's NPI submission process and how NCPDP can work with you, contact Jeannine Deese (480) 477-1000 ext. 116, or at jdeese@ncpdp.org ❖

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Pharmacists Mutual is endorsed by the North Carolina Association of Pharmacists (compensated endorsement).

Quality : First Duty of Every Pharmacist

By Kenneth R. Baker, RPh, JD[1]
Executive Director
Pharmacy Compounding Accreditation Board

We talk a lot about the changing nature of pharmacists' legal duties. Is there a "duty to counsel" or a "duty to monitor for allergies?" Such debates are interesting and still somewhat unsettled. A reading of court decisions in Massachusetts and Texas lead the researcher down one path while Illinois and Missouri courts point in the direction of an opposite answer. One pharmacist duty, however, is universally accepted – the duty to fill the prescription correctly. It is the oldest duty: "First, do no harm."

Reading newspaper accounts and watching tabloid style television reporting might give someone the idea that we as pharmacists are failing in that duty. In a January 2004 story in the Wall Street Journal it was announced that community pharmacists deliver to their customers over 50 million errors each year. Over 3 million of those errors, the article continues, contain a serious or potentially fatal mistake. Those numbers are not just hype – they are calculated from a carefully documented and researched observational study by Doctors Flynn and Barker at Auburn University School of Pharmacy. The study was published in the Journal of the American Pharmacists Association the year before the Wall Street Journal article appeared. These numbers are, however, only a part of the story.

In actuality the story is that pharmacists do a good job of "first, do not harm" under trying circumstances. Community pharmacists filled over three billion prescriptions and of the 50 million mistakes cited, 99.99% were things like misspelled prescribers' names and other things unlikely to result in harm. The one in 10,000, or three million, that could have caused harm must be compared to the move than 3 billion filled to understand the true picture – a 99.9% accuracy rate.

Still, one error that reaches a patient, even if only a misspelling, is too many. There is plenty of room for improvement. As good as we are, we can do better. –"I am busy" is not an excuse for making a mistake on a patient's prescription. Neither is,'"I need more help." We will always be busy and we will never have as much help as we think we should.

Pharmacists are one of the most trusted professionals because they do not make excuses and because pharmacists really do care for their patients. Every pharmacist's greatest nightmare is making a mistake that causes injury to one of his or her patients. Every pharmacist has at one time or another awakened in the middle of the night with the thought of "Did I do that right?"

The good news is we can do better. We can raise quality to an

even higher level. The answer is through the introduction of an organized system of continuous quality improvement in each pharmacy. Every pharmacist and every pharmacy technician uses several tested and proven best pharmacy practices designed to prevent a mistake from happening or catching a mistake before it becomes an error by reaching the patient. These best practices include NDC checks and bar code scanning and triple checks. These are excellent moves toward quality, but they are only the first moves.

Continuous quality improvement, or CQI, incorporates these and other best practices into an organized workflow system. Best practices are good, but it is the organized workflow that allows them to work to their maximum potential. Implementing CQI in pharmacies, both community and hospital, is not only possible it is also relatively easy and very affordable, thanks to an initiative by pharmacists for pharmacists.

A coalition of all 50 state pharmacist associations in the United States, in cooperation with Pharmacists Mutual Insurance Company, are making a CQI program, specifically designed for pharmacy practice, immediately available to all dispensing pharmacies in the United States.[2] The state associations have formed a not for profit company, the National Alliance of State Pharmacy Associations, LLC, for this purpose.

The state pharmacist associations' program is unique among national programs. It is the only one specifically designed for pharmacy that meets all of the criteria outlined by the Institute of Medicine's publications on reducing medical errors, beginning with its 1999 report to Congress, "To Err is Human."

The workflow, called the Sentinel System℠, is combined with a system of recording, through a secure Internet site, not only errors but also near-misses. This piece of the quality system offered through the state associations is called the Quality Manager℠. While many pharmacies record their failures of quality through incident reports, the Quality Manager℠ also records successes – the times the quality system worked by preventing mistakes to reach the patient and become errors. Any pharmacy recording only failures should seriously consider the other side of documentation. Successes, near-misses, also give more information that can be used to continuously improve quality.

Pharmacists' reputation for trustworthiness is well deserved. We should all applaud the state pharmacist associations for their efforts to help us to maintain that reputation. Now, it is up to us to take the next steps. If your pharmacy does not currently use an organized system of CQI, including a system to learn from every error and near-miss, consider implementing one. Call, or tell the boss to call, your state pharmacy association or develop your own system or find another one, but do not wait for the next sleepless night. ❖

[1] Ken Baker was formerly Sr. Vice President, General Counsel for Pharmacist Mutual Insurance Company.

[2] In accordance with full discloser, the reader should be aware that the CQI program being marketed by the states was designed by the author and University of Florida professor David Brushwood, RPh, JD. The program was formerly marketed by PMC Quality Commitment, Inc., a subsidiary of Pharmacists Mutual Insurance Company. The National Alliance of State Pharmacy Associations, LLC was formed to purchase the Pharmacy Quality Commitment® program from Pharmacists Mutual, who will receive payment from the sales generated by the National Alliance of State Pharmacy Associations, LLC.

Small Doses

PHARMACY ORGAIZATIONS RECEIVE SPIRIT OF INDEPENDENCE AWARD

Eleven pharmacy organizations were named recipients of the National Community Pharmacists Association's (NCPA) Spirit of Independence Award at NCPA's 107th Annual Convention and Trade Exposition now underway in Fort Lauderdale, Fla.

First presented in 2004, the Spirit of Independence Award is given to individuals or organizations that have gone above and beyond the norm in their support of independent community pharmacy and NCPA. The inaugural recipients of the award were the members of the Community Care RxSM board of directors.

The 2005 recipients are:

- American Pharmacy Cooperative, Inc.
- Dakota Drug, Inc.
- Dik Drug Company
- F. Dohmen Company
- Independent Pharmacy Buying Group
- Keystone Pharmacy Purchasing Alliance
- McQueary Brothers Drug Company
- NC Mutual Wholesale Drug Company
- Partners in Pharmacy Cooperative
- Rochester Drug Cooperative, Inc.
- Smith Drug Company

"These organizations are being recognized with NCPA's 2005 Spirit of Independence Award for going the extra mile in support of NCPA and independent pharmacy," said Bruce Roberts, RPh, NCPA executive vice president and CEO.

"REACH ONE FOR NCAP" WINNER

John Kessler is the winner of a free 2006 NCAP membership for his participation in the "Reach One for NCAP" membership campaign. Names of those who recruit new members are included in a drawing held each year at the Annual Convention.

MIXON INDUCTED INTO ELITE FELLOWSHIP

Bill Mixon received one of the Independent Academy of Compounding Pharmacists highest honors at their annual meeting held June 6 in Washington, DC. He was inducted into the Fellows of the Academy. The induction completes a stringent Fellowship process that began over a year ago. Completing these steps places him among the elite in the profession.

FERRERI RECEIVES CCPF AWARD

Stefanie Ferreri was presented the NCAP Community Pharmacist of the Year Award at the Pharmacy Practice Seminar last September in Wilmington.

Calendar

March 5-6: ***Community Care Practice Forum Meeting.*** Chapel Hill Sheraton.
March 23-24: ***Chronic Care Practice Forum Meeting.*** University Hilton, Charlotte
April 8: ***Student Pharmacist Leaders Conference*** FirstHealth, Pinehurst, NC
April 24-26: ***Acute Care Practice Forum Meeting.*** Sheraton Four Seasons, Greensboro.
July 14: ***Residents Leadership Conference.*** Friday Center, Chapel Hill.
Sept. 8-10: ***Pharmacy Practice Seminar*** Wilmington, NC.
Oct. 22-24: ***NCAP Annual Convention,*** Sheraton Imperial, RTP, NC.

Southeastern Girls of Pharmacy Leadership Weekend

January 20-22, 2006
Grove Park Inn, Asheville NC

With fall upon us, the 4th Annual Southeastern Girls of Pharmacy Leadership Weekend is just around the corner. Leave your cares at home and let this weekend be All About You!

This year's event will offer 9 hours of live CE on female specific topics. In addition to a panel of expert speakers, Dr. Ally Dering Anderson is back by popular demand to present the opening and closing education sessions. This year's fantastic topics include:

Nutrition and Weight Management
Leadership for Women
Cancers in Women
ADD/ADHD in Women and Children

As in the past, there will be plenty of time for relaxing spa treatments, reunions with past attendees and friends, networking opportunities and taking in all that the beautiful Grove Park Inn and Asheville, NC have to offer.

To make your hotel reservations, call the Grove Park Inn 800-438-5800. Mention the Southeastern Girls of Pharmacy Leadership Weekend to receive the special $122 rate.

Spa reservations may be made by contacting the South Carolina Pharmacy Association 800-532-4033. Spa appointments are in great demand, so make your appointment early!

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Registration Fee: NCAP Member $175 Guest of NCAP Member $100
Non Member $275 Guest of Non Member $150
Name of Guest_____

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*Program handouts will be distributed by CD. If you would like to receive paper copies as well, please check here. ☐

Return to NCAP 109 Church St. Chapel Hill, NC 27516 (ph)919-967-2237 (fax) 919-968-9430

North Carolina
Pharmacist

Volume 86, Number 1 ...applying drug knowledge to improve health Winter, 2006

Changing of the Guard

Jack W. "Jay" Campbell (r) has been appointed Executive Director of the North Carolina Board of Pharmacy. He will replace David Work who is retiring after 30 years of service. Board members (l to r) Rebecca W. Chater, Vice President, Asheville; Robert L. Crocker, Farmville; J. Parker Chesson, Jr., Durham; David R. Work, Executive Director; L. Stan Haywood, Asheboro; Wallace E. Nelson, Hertford; and Betty H. Dennis, President, Carrboro. *Story on page 8*

Upcoming NCAP Meetings:

- Community Care Practice Forum Meeting, March 5-6, Chapel Hill

See page 6 for a special registration offer

- Chronic Care Practice Forum Meeting, March 23-24, Charlotte

Official Journal of the
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North Carolina Pharmacist

Volume 86, Number 1 Winter, 2006

Inside

Special Continuing Education Supplement

In order to better serve our members, NCAP will mail a special CE supplement only to members who request it. If you would like to be added to the CE mailing list please contact Teressa Reavis at teressa@ncpharmacists.org or call 919.967.2237 ext. 22

URGENT

Important information for pharmacists treating patients with glaucoma

FDA: Generic Substitution for BT-Rated Meds Carries Risk

The Legal Necessity of Ensuring Bioequivalence

The FDA grants BT ratings only to drugs with no recognized bioequivalent.

Bioequivalent drugs, according to the Orange Book, "can be expected to have the same clinical effect and safety profile when administered to patients under the conditions specified in the labeling." The Orange Book remains the definitive authority on drug bioequivalence.

Pharmacists may be unaware that ophthalmic beta-blocker Istalol® (timolol maleate ophthalmic solution) 0.5% carries a BT rating.* No drug is bioequivalent to Istalol®. *It may be illegal in your state to substitute BT-rated products.* Check pharmacy laws in your state. Such substitutions have the potential to place a pharmacist's professional license and personal assets at risk. Moreover, a pharmacist who substitutes a drug that is not bioequivalent may be negligent and, should that negligence result in injury to a patient, a legal cause of action may be established against that pharmacist.

"Istalol® carries a BT rating. No drug is bioequivalent to Istalol®."

How can pharmacists ensure they are selecting bioequivalent medications, thereby protecting themselves and their patients? *Pharmacists should refer to the FDA authoritative source, the Orange Book.* In many states, the Orange Book is the only official reference for bioequivalence. Caution must be used when employing pharmacy software programs that only list generic equivalents and do not indicate whether a drug has a BT rating.

As clearly indicated by the FDA BT rating, no other product, including generic timolol, is therapeutically equivalent to Istalol®, and therefore cannot be substituted for it. To do so may be a violation in your state.

*FDA Orange Book 2005.
ISTA Pharmaceuticals®, Inc.

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NCAP Open House

Due to the generousity of the Pharmacy Network Foundation, NCAP members, and friends, the Institute of Pharmacy building (home to NCAP) has been renovated. Last year the historic building, which sits at the corner of Church and Rosemary Streets in Chapel Hill, received much needed updates both inside and out. To help us celebrate our new and improved environment,

NCAP members and their families are cordially invited to attend an

Open House

Sunday, April 9, 2006

2:00 to 4:00 pm

Comments and Auditorium Dedication 3:00 pm

Institute of Pharmacy

109 Church St.

Chapel Hill, NC

Please RSVP Linda Goswick, 919-967-2237 or linda@ncpharmacists.org by March 27, 2006.

Fred Eckel

A Message From the Executive Director

Out with the Old, in with the New

North Carolina Pharmacy is facing a transition. Change always brings opportunities. It is often up to us to create the opportunities, however, NCAP has had a strategic goal to "address the relationship of NCAP with the Board of Pharmacy on behalf of the profession." During 2005 we focused on working with the Board to address the idea of Continuous Professional Development as a competency tool for pharmacists. We also prepared some recommendations for technician role expansion through a Technician Task Force that included Board members. Recently NCAP created a Task Force to help determine the role we should play in creating a culture of safety and quality in North Carolina Pharmacy (see story, page 17). In setting up this Task Force it was recognized that NCAP will have to work cooperatively with the Board of Pharmacy to achieve the desired results. My pledge to NCAP members is that we will continue to devote our energies on strengthening the relationship between NCAP and the Board of Pharmacy. We are planning the annual Update on NC Pharmacy regional meetings for the first two weeks of May. A major focus of these meetings will be to introduce the new NCBOP Executive Director Jay Campbell to pharmacy professionals in North Carolina. The Board of Pharmacy has again provided NCAP with a grant to conduct these programs without a registration fee. Make plans now to attend this year's Update and meet Jay Campbell.

As excited as I am to work with Jay Campbell, I will miss working with Dave Work. Dave and I joined the faculty at UNC around the same time so we have had a long association. His retirement reminds me that mine will probably occur soon too. Dave leaves a legacy in pharmacy, just as his predecessor H.C. McAllister. Mr. McAllister cared about pharmacy and was resourceful and innovative. It was the opportunity to work with him on the Plan of Pharmacy Assistance that helped convince me that boards of pharmacy play a key role in the profession of pharmacy. Dave continued the North Carolina tradition of a strong Pharmacy Board and his contributions will be long remembered.

Thank you, Dave, for being a great colleague, a real visionary, someone who cares about the disadvantaged, a critic of the status quo, and a teacher to many, including myself. May the next phase of your life bring you enjoyment and hope. The profession and I will miss you.

Finally, a word about NCAP. To strengthen our service to community pharmacy, NCAP's Community Care Practice Forum has developed their own meeting scheduled for March 5-6, 2006. If we had known what Medicare Part D would do to community pharmacy we would not have started this meeting in March. But we have, and now we need to make sure this meeting is successful because we know this is the right thing to do. We need members to come for at least one day so we are extending the early registration discount until Feb. 28. If you register (or have registered) by this date, we invite you to bring one additional colleague for no additional fee as long as they are pre-registered by Feb. 28. We need your help. Please support our Community Care Practice Forum meeting.

Community Care Practice Forum Meeting Special Offer

Sunday & Monday, March 5-6, at the Sheraton Chapel Hill Hotel

To strengthen our service to community pharmacy, NCAP's Community Care Practice Forum has developed their own meeting scheduled for March 5-6, 2006. If we had known what Medicare Part D would do to community pharmacy, we would not have started this meeting in March. But we have, and now we need to make sure this meeting is successful because we know this is the right thing to do. We need members to come for at least one day, even though the timing is inconvenient, so **we are extending the early registration discount until Feb. 28. If you register by this date, or have already registered, we invite you to bring one additional colleague for no additional fee as long as they are pre-registered by Feb. 28.**

We have invited psychologist Wayne Sotile, PhD, to "kick off" our meeting, with the entire opening session dedicated to coping & thriving with stress in our workplaces, plus helping us thrive in our ever-increasing, dual-career families. Monday morning's presentations start with Myelita Melton, MA, a dynamic speaker, who has been teaching our nation's pharmacists about Hispanic "health culture" & use of medical Spanish. We have great afternoon speakers who will address medication safety, new OTC drugs, & immunization services. And on Saturday, **March 4, we have a pre-meeting IMMUNIZATION CERTIFICATE PROGRAM,** held at the Institute of Pharmacy. All presentations at this meeting are meant specifically for ambulatory care and community pharmacists to help them advance their professional knowledge & skills. Please join your community pharmacy/ambulatory care colleagues and obtain 10 to 30.5 hours of CE credit at the same time. Please contact NCAP Executive Director, Fred Eckel (919-967-2237 or NCAP Postgraduate Education Director, Steve Caiola (919-966-4557) if you have any questions.

See you in Chapel Hill March 4, 5 & 6!

North Carolina Association of Pharmacists
109 Church Street
Chapel Hill, NC 27516
phone: 919 967.2237 • fax 919.968 9430


Dennis Williams

I hope that your transition to 2006 was enjoyable, productive and successful. Certainly, the new year offers many challenges and opportunities for our profession. Today, pharmacists in community and long-term care settings are in the throes of the Medicare prescription drug benefit program that promises to occupy our time as more and more patients select their plan. And pharmacists in health systems are working tirelessly on multidisciplinary committees to address medication reconciliation strategies and rapid response teams. These relatively new challenges are added to an already packed agenda for each of us. I commend every one of you for your dedication and willingness to work on solutions to these important issues that should improve problems with access to medications, optimize outcomes from drug therapy and ensure safety in the use of medications.

The face of pharmacy is changing across the United States and certainly in North Carolina. In 2006, we will see a transition in the leadership for our Board of Pharmacy. Clearly, David Work represents an "institution" to most pharmacists in our state. His career has been dedicated to advancing pharmacy practice and ensuring the safe and effective use of medications. We are looking forward to developing a new relationship with Jay Campbell and we likely will see changes as expected when there is a transition in leadership. After all, it is impossible to replicate the boy from Iowa who is as close to being a true North Carolinian as any native. NCAP extends a collective thank you and best wishes to David and Rebecca.

Speaking of NCAP, I want to acknowledge how much I enjoyed serving on the Board this past year under the leadership of President Davie Waggett. The commitment and diversity of our Board members is commendable and I hope that each of you also appreciates the efforts of Fred Eckel and the NCAP staff to stay on top of issues important to North Carolina pharmacists.

A recurring theme that you will hear from me this year is, "What would pharmacy look like in North Carolina if there was no NCAP?" We may have reached the point where we sometimes take for granted the value of having an organization representing our professional needs. You can easily reach that conclusion if you look at the small fraction of pharmacists who chose to sustain their membership in NCAP. To you as a current member, NCAP is grateful. NCAP makes decisions about programs and resources based on what is collectively best for our profession. NCAP does its best to advance the profession and represent all pharmacists, even those who choose not to support us by declining invitations of membership.

Here is a brief snapshot of what you can expect to see and hear from NCAP during 2006. Our state pharmacy organization will be reviewing the constitution and bylaws adopted just a few years ago when NCAP was formed as a merged organization. This is an important task because of the implications it will have in formalizing and improving our communication with the national organizations that our members are associated with. We also will be instituting various councils and committees to address issues and provide insight and suggestions for our organization. There will be new opportunities for member input and involvement and I encourage each of you to consider what valuable input you can offer.

NCAP will focus on three major strategic directions in 2006. They are listed below in order to be clear and concise:

Identify, develop and provide resources for pharmacists to help them provide quality and care and services to patients. NCAP will accomplish this through educational programming, products and services. NCAP will continue to monitor the environment that we operate in and look for partnerships with other health-related groups.

Increase awareness and involvement in the state and federal legislative process. This includes enhancing understanding and the effectiveness of individual members who communicate with elected officials in our communities, state and country.

Ensure that we are serving the needs and expectations of a diverse and growing membership. NCAP will continually evaluate what we are doing for our current members and what value we bring to our membership in general.

Here is a biased opinion: Every pharmacist in North Carolina benefits from the efforts and activities of NCAP. NCAP is a central body representing all pharmacists practicing in the state. If the state association didn't exist, many questions, needs and opportunities that arise each day would not be addressed. Many of you may not be aware of the contacts, interactions, and discussions that occur daily between NCAP staff, leadership and other health, government, public, and academic groups.

With the pressures and financial demands that we all face, I understand how decisions are made when the annual dues of NCAP arrive in your mail. Nonetheless, pharmacists enjoy record salaries and benefits today, and the cost of supporting an association who is singularly focused on the needs of all pharmacists is minimal. Please don't hesitate to renew your membership or join again. If you have a second thought, then think carefully about what might happen without NCAP.

Best wishes for 2006,
Dennis Williams, PharmD
President, NCAP

...applying drug knowledge to improve health

The North Carolina Board of Pharmacy

Changing of the Guard

After 30 years of outstanding service, David Work, Executive Director of the North Carolina Board of Pharmacy, is retiring. The Board conducted a national search and selected Jack W. "Jay" Campbell IV as his replacement. Campbell started with the Board on February 1 and is working as Associate Executive Director during a short transition period.

Betty Dennis, President of the Board of Pharmacy, expressed great satisfaction with the outcome of the search. "We had several very strong candidates, which I think speaks to the national reputation of the North Carolina Board of Pharmacy. Jay Campbell is a native North Carolinian and has been recognized for his achievements both in pharmacy and in law. We are very fortunate to have attracted someone with his experience and ability."

Campbell, a native of Sanford, NC, is a 1993 graduate of the UNC School of Pharmacy and a 1997 graduate of Vanderbilt University School of Law. He was valedictorian of his class at both universities. After graduating from UNC, he worked in pharmaceutical research and in community pharmacy before entering law school. Upon completion of his law degree, he served in a clerkship for The Honorable Bruce Selya, a judge on the US Court of Appeals for the First Circuit. Other work included practicing law with Jones Day, a large multi-national firm in Washington, DC and most recently in Charlotte, NC with Helms, Mulliss & Wicker, a large North Carolina-based law firm. While working in the latter position, he served as an adjunct professor at the Wingate University School of Pharmacy.

David Work, Executive Director, NCBOP

Passing the Torch

by David R. Work, RPh, JD
Executive Director
North Carolina Board of Pharmacy

Things have changed a lot since I first came to the Board in January of 1976. Our budget for that year was about $135,000 which doesn't seem like much compared to our current budget of $2.8 million. We had a total of six employees and two of those were inspectors in the field. One of the inspectors, Lloyd Davis, moved to a half-time basis during my first year. Today we have 22 employees and two offices with nine positions assigned to inspections and investigation field staff.

We have many more responsibilities now than in 1976. The Board began registering pharmacists in 1881 and added pharmacy permits in 1928. Since 1976 we have added registrations for dispensing physicians, physician assistants, nurse practitioners, DME dispensers and, most recently, pharmacy technicians.

Certainly the most significant new practice category is that of Clinical Pharmacist Practitioner which was created by the General Assembly in 1999. This was the main legislative project of the North Carolina Association of Pharmacists that year, and is unique in the United States. This made practice advances possible through agreements with physicians, which eventually included prescribing drugs and controlled substances if covered under the agreement. There is no doubt that a lot has happened in pharmacy practice in the last 30 years.

I am confident that my successor, Jay Campbell, will continue and improve the Board's reputation for being a progressive force for healthcare in this state. I believe he can be compared to Bill Friday, the now retired president of the UNC system, in at least one way. I have never heard anyone say a bad thing about Bill Friday or Jay Campbell.

There is a lot of transitioning in health care today and the North Carolina Board is in an excellent position for maximum input on that process.

Replacing the Irreplaceable

by Jay Campbell, BS, JD
Associate Executive Director
North Carolina Board of Pharmacy

When interviewing for the position of Executive Director of the North Carolina Board of Pharmacy, I was struck by David Work telling me that, if selected, I would become only the fifth ever executive director, a post that traces back to 1887. I replied that there have been fewer executive directors in that period than Chief Justices of the United States.

That comparison has other aspects. The fourth Chief Justice of the United States was John Marshall. David is the fourth executive director. Chief Justice Marshall served for 34 years. David served for 30. History regards Marshall as "The Great Chief Justice." His 1803 opinion in the case of Marbury v. Madison is the wellspring from which practically all constitutional law flows. David is viewed, and will always be viewed in my opinion, as "The Great Executive Director," someone who guided the practice of pharmacy in North Carolina (and, to some extent, the nation) through periods of enormous change. Like Chief Justice Marshall, David has never been inhibited from encouraging the Board to do the "right

thing" from a practice and public-safety standpoint, even when doing the right thing meant a substantial departure from prior practice or precedent.

It is at this point, though, that I hope the parallels end, at least for my sake. Chief Justice Marshall's successor, Roger Taney, though regarded as a kind and decent man, is someone who history, with some good reason, has judged harshly. But I have a great advantage over Taney. Taney never served as an associate justice under Marshall. I have the luxury of serving, for a short period at least, as associate executive director under David's tutelage. Moreover, Taney succeeded a deceased Marshall. David will be available – whether he likes it or not! – to help guide me through the transition and to serve as a mentor, hopefully for many years.

Even so, I find myself asking, "How do you replace the irreplaceable?" The answer, of course, is that you cannot. So, you may ask, "Who is this guy who must nonetheless attempt the impossible?"

I graduated from the UNC School of Pharmacy in 1993. During my time at UNC, I first became interested in law due in no small part to some work I did with the Board in general, and David specifically, bringing about changes in the rules governing pharmacy internship hours. Prophetically, as it turns out, I remarked then to friends that I thought David's position was a fascinating one that I might be interested in some day. After some time spent working as a researcher for a pharmaceutical company and as a relief pharmacist for a drug chain, I attended the Vanderbilt University School of Law and graduated in 1997. Following a judicial clerkship with Bruce Selya of the United States Court of Appeals to the First Circuit (a man who would have made a terrific Chief Justice himself), I practiced appellate law for a large, multi-national law firm in Washington, DC for six years.

The pull to return home, however, eventually proved impossible to resist, and I returned to North Carolina to practice law in Charlotte in 2004. I also discovered that in my absence Wingate University had opened a school of pharmacy, and Dean Robert Supernaw took a chance and hired me to develop and teach the Pharmacy Law class. I am profoundly grateful to Dean Supernaw for that opportunity. It allowed me to reconnect with the practice of pharmacy and to reacquaint myself with the myriad of legal and policy issues that face the profession.

I come to this position with tremendous enthusiasm and excitement. And, as David reminds me, I'm going to need it. I am not so presumptuous as to outline today a grand vision of how I see my tenure unfolding. Rather, let me say that I recognize the evolving nature of the profession, which brings with it additional opportunities to serve patients and the public, as well as growing pains. The legal and policy matters pertinent to the profession are becoming more complex. Among other things, the interplay of, and at times conflict among , federal and state regulations pose a growing set of challenges and opportunities. And as the regulatory and policy interactions in the profession become more complex, practitioners deserve clear, proactive guidance from regulators.

I look forward over the coming months to getting to know as many of you as I possibly can; to hearing your concerns, ideas, and commentary; to understanding the often competing desires among different constituencies within the profession; and, most of all, doing my best to live up to the high standards that David has set at the Board.

From the President

by Betty H. Dennis, PharmD, MS, CDE, CPP, FASHP
President, North Carolina Board of Pharmacy
Senior Clinical Specialist, Ambulatory Care Department of Pharmacy, UNC Hospitals
Clinical Associate Professor, UNC School of Pharmacy

It is a tremendous honor and privilege to be elected by the pharmacists of North Carolina to represent them as a member of the North Carolina Board of Pharmacy. I am humbled by this trust expressed by my colleagues across the state, and committed to the responsibilities of Board membership.

Personally, I'd like to thank NCAP for focusing on the North Carolina Board of Pharmacy in this issue of the journal. We appreciate the invitation to both current and past board members to share our backgrounds, experiences, and perspectives on the role of the Board and changes we anticipate in the future.

Throughout my 30+ year career, I have heard many times that North Carolina has a "special situation" as compared to other states, and thus can be progressive with advances in practice due to the collaborative relationship between the Board, the Schools of Pharmacy and the professional organizations. In my four short years on the Board, I've learned first hand how true this is and how important and valuable such a collegial relationship is to ensure safety in pharmacy practice.

First, I'd like express my congratulations to David Work for his many years of service as Executive Director of the Board. His dedication to the citizens of North Carolina and our profession is remarkable. He is truly a legend in North Carolina Pharmacy, and has always been available to listen and advise. My law book has many notes from over the years such as "9/82-per phone call to Dave W....its ok to..." This legend is retiring and I now realize how fortunate we've been to have someone with such wisdom so readily available to assist with issues, challenges, and concerns. Dave works tirelessly, often in the background, to keep us current and in tune with our responsibilities for the safe use of medications and protection of the public. His advice gives confidence and support as we develop new ideas and practice initiatives. Thank you Dave for your many efforts to promote safe pharmacy practice and support our practitioners over these 30 years!

It was with great pleasure that the Board announced a few weeks ago the hiring of Jay Campbell, RPh, JD to assume the role of Executive Director upon Dave's retirement. We are fortunate to have someone who has demonstrated such excellence in both pharmacy and law to meet the challenges of being Dave's successor.

We are proud of the many advances made by previous Board members, and the excellent reputation gained by our Board. Under Dave's leadership, the Board has a superb staff that provides friendly and supportive advice to students who prepare for licensure, pharmacists seeking reciprocity, and practitioners who have issues or concerns. We want our Board to be friendly, supportive and easy to approach by students, pharmacists, technicians, as well as other healthcare providers and citizens of our state.

When I considered participating in the election for Board membership five years

ago, I was asked why I wanted to serve in this capacity when the Board is often viewed as a disciplinary agency. Although the responsibility to regulate the practice of pharmacy does include discipline, the Board is mandated by statute to use this regulatory authority "in order to safeguard and protect the life and health of the people of North Carolina, and in order to promote the public welfare." This is the responsibility that intrigues and challenges me. It offers an opportunity to use my years of experience to support development of initiatives that promote safe practice, enhance patient care and education, and elevate the visibility of pharmacists as public health resources for their communities. Regardless of the practice environment of our Board members, or differences in personal philosophies and backgrounds, we are all dedicated to ensuring the safe use of medications by the citizens of our state, and promoting public health through the practice of pharmacy.

This is the fourth year of my five-year term, and I'm serving as Board President through May. Our six Board members bring expertise from various pharmacy environments. In addition to five pharmacists, we have one public Board member who has extensive experience with governing boards and the community college system. This diversity in membership is important and enables us to give appropriate consideration to the impact of new rules and policies on the many different models of pharmacy practice.

I've been fortunate to have a varied practice background that includes ambulatory care pharmacy; clinic-based patient care and education; inpatient services; and educational responsibilities as a faculty member and preceptor of students and residents. Each day I strive to practice professionally, ensure safe practice, and adhere to all the state and federal laws. It's the "grey" areas of regulation that can be most challenging… those situations where we must use our judgment and experience to do what we believe is in the best interest of our patients.

I'm proud that our Board, through the efforts of past and present Board members, supports the pharmacists' role to use professional judgment in patient care decisions, while recognizing that there will be variability in the decisions that are made. The Board has developed rules that allow pharmacists to provide emergency refills of chronic medications in certain conditions. These rules have prevented interruptions in critical therapies, especially during natural disasters such as hurricanes and floods.

We all feel the daily stress of the tremendous responsibility we have for safe practice as we provide medications to patients. No pharmacist wants to make an error, and no manager or owner wants to be responsible for an environment or system that increases the risk of errors. Unfortunately, errors occur and we actually have an increasing number of reports of medication errors made to the Board. How can we work together to reverse this trend?

As practitioners, we realize that a single moment of distraction can literally mean the difference in life or death of a patient. Therapies are increasingly complex, prescription volume is increasing as we face critical shortages of personnel, Medicare D issues are confusing, insurance claims often delay prescription processing, and that phone never seems to stop ringing. A priority for our Board is to develop and support statewide initiatives for safe practice. We envision a program that will help us recognize and develop strategies to minimize factors that contribute to medication errors. We need to have a process that will allow us to share our experiences in a non-punitive manner to prevent recurring problems. Throughout the history of our Board, efforts have been made to enhance understanding and compassion during review of the many factors involved in medication errors.

One of the most difficult aspects of

Demonstrating Leadership

by Al Lockamy, RPh
Ten Year Member, North Carolina Board of Pharmacy
Blue Ridge Pharmacy, Raleigh, NC

I was the first Community Chain Pharmacist to be elected to the North Carolina Board of Pharmacy in 1990 and served two five-year terms. During my tenure the whole complexity of the Board seemed to change. At that time our goals included visibility, leadership, expanding pharmacists responsibilities, and electronic enhancements in the profession.

The Board was perceived as the "Supreme Court of Pharmacy" in North Carolina. Pharmacists did not only not know the Board members, but had never seen them at any pharmacy functions. To improve our visibility we scheduled Board hearings and functions convenient for student audiences, and public hearings were held in different regions of the state to allow more pharmacists to participate. Board members presented law review seminars and represented North Carolina Pharmacy at state and national pharmacy functions. Several members also served on national committees.

Regulations were enacted to allow pharmacists to use their professional judgment, e.g., dispense a 30 day refill for maintenance medications if the MD is not available on weekends or in case of a national emergency or, if a prescriber leaves their practice the pharmacist may dispense a 90 day refill. The Clinical Pharmacist Practitioner Act was passed which allows pharmacists to prescribe under protocol. The Board also began registering and tracking all pharmacy technicians.

Electronic enhancements included allowing faxed prescriptions and electronic transfer of prescription information. Graduates began taking the National Board Exam by computer and the State Exam was rewritten for electronic grading.

Board members demonstrated leadership not only in pharmacy, but in other areas of their lives. Whit Moose was the national president of NCPA and an accreditation member of AACP. Jack Watts served on his local school board for 36 years and as president of the North Carolina School Boards. Harold Day was elected NABP honorary president and Dave Work served in all offices of NAPB, including as president. I served as president of APhA Academies of Pharmacists and as Board representative on the AACP accreditation team. Our Board was honored by NAPB as National Board of the Year and Steve Hudson was named National Board Inspector of the Year! All five members were previously honored as NCPhA (NCAP) Pharmacists of the Year and three members have received Honorary Doctorate degrees and awarded the Keith Fearing Community Pharmacists of the Year.

Board membership is careful consideration of cases involving impairment or drug diversion. I have been surprised at the number of situations that involve these issues, yet recognize that the stress of practice can contribute to decisions that jeopardize both the patient and practitioner. The Board strongly supports efforts to prevent impairment, and financially supports the Pharmacist Recovery Network (PRN) that provides counseling and monitoring services for practitioners in recovery.

I've learned through experience that communication and collaboration are essential to unite our profession to achieve advances in practice initiatives while promoting the highest standard of safe practice. While the Board cannot lobby legislators as NCAP can, our new Vaccine Rule demonstrates the success that can be achieved by the combined efforts of many to gain legislative approval and support from the medical and nursing boards to implement rules that have significant public health benefit. North Carolina pharmacists can now expand their public health role and provide increased access to pneumococcal and influenza vaccines. Pharmacists are also expanding their patient care services as Clinical Pharmacist Practitioners who have collaborative agreements with physicians in their communities to provide drug therapy management. A new rule has been approved to facilitate implementation of innovative pilot distribution and patient care programs so practitioners can gain valuable experience that will assist the Board as it develops new rules and policies.

Several initiatives have been developed to enhance communication with the Board. Each spring, the Board supports and cosponsors programs throughout our state with our three Schools of Pharmacy and NCAP to provide updates on practice issues and listen to ideas, suggestions and concerns. We have implemented an "Open Mike" session at monthly Board meetings to facilitate communication with practitioners and organizations. Also, each of our three Schools of Pharmacy has appointed a Board liaison to promote communication with students, faculty and alumni. Practitioners are invited to participate on various committees and task forces concerning policies and proposed rules.

Issues that will challenge us in the future include: advances in automation and technology that impact prescribing, documentation and systems for delivery of medications; programs for quality assurance and safety to reduce medication errors; the role of pharmacy technicians and supportive personnel in the dispensing process; adequate payment for comprehensive pharmacy services that includes both dispensing of a product plus patient care services such as counseling that are mandated by law; compounding and other special patient care services; new models of practice for enhanced patient care; prevention of impairment and drug diversion; and continuing professional development and competency. We need communication and collaboration with our practice community to achieve advances in these areas. Please let us know your suggestions as we consider these and other practice issues.

I've been very fortunate throughout my career to have excellent mentors who provided many opportunities to collaborate with other pharmacists and healthcare professionals to develop programs, services and legislation. My membership in NCAP has provided opportunities for me to sit side-by-side with other practitioners from all environments of practice, debate issues, and gain a greater understanding of different needs and concerns throughout our practice community. I encourage you to take an active role in our profession through personal communication of ideas and suggestions, committee participation and leadership roles. Together we can... and should decide our future...rather than letting others decide it for us.

I look forward to continued service on the Board. Please let me know your ideas and suggestions.

A Proactive Board

by Rebecca W. Chater, RPh, MPH, FAPhA
Member, North Carolina Board of Pharmacy
Director of Clinical Services
Kerr Drug, Inc./KDI Clinical Services

I am very honored to serve on the North Carolina Board of Pharmacy--the only Pharmacy Board in the nation elected by the pharmacists of its state. Having a career-long passion for patient care, my work within our Board is framed by my personal belief that we can best fulfill our primary charge to protect the public safety by doing everything within our regulatory authority to support the pharmacist's role in providing quality patient care. Therefore, I believe that our Board should promulgate Rules that always have patient safety as a first priority, but that are also consistent with the realities of contemporary pharmacy practice.

It has been very rewarding to serve alongside fellow Board members and staff who are equally committed to ensuring public safety and improving patient care. Our current Board has a good balance in terms of practice setting representation. Among our pharmacist-Board members, we collectively have over 130 years of pharmacy experience in hospital, independent, and chain practice, as well as long-term care and academia, not to mention the best gender balance in the history of the North Carolina Board of Pharmacy. It is especially nice that we have been able to achieve that balance by your votes, rather than having the complexion of our Board mandated by state government, as is the case in many other states. Because we come together as pharmacists, who have lived the same practice lives you live day-to-day, our approach to addressing issues that come before us is very grounded, not wrought with the hidden agendas that often plague a Board populated with political appointees.

Our current Board, as well as pharmacists and other citizens of our state, owe a debt of gratitude to previous Board members, who over the course of more than 100 years have provided the North Carolina Board of Pharmacy with such a rich, commendable history. Previous Board members who served prior to the time that our existing term limits were in place dedicated as many as 30 years or more of their lives to service of the Board. It is truly difficult to imagine that kind of commitment today. Long before I was a Board member, I knew of the long standing national reputation of our Board for being very proactive and innovative. Also, were it not for the tireless dedication of David Work as Executive Director, as well as those who preceded him in that capacity, this would not have been the case.

There are many lessons I have learned during my tenure on the Board. One of great value in terms of my service to the Board is the extreme care required in developing language for policy-making so that the policy does precisely what it is intended to do, and nothing more. Rules and statutes that are not

meticulously crafted can have very harmful unintended consequences. Anticipating these and making language specific enough to avoid them, yet broad enough to have the intended impact, is a real art. This is an area where Board legal counsel has been a tremendous resource.

A great awakening for me in my experience as a Board member has been the pervasiveness of pharmacist impairment due to drug addiction. Witnessing the personal lives of colleagues and their families needlessly devastated by addiction has made a lasting impact on me personally. On a brighter note, I have also been nothing short of amazed at some of the recoveries I have seen through the North Carolina Pharmacist Recovery Network (NCPRN). I would like to encourage anyone reading this who may have a problem with addiction or who knows a colleague who may be impaired to please contact Paul Peterson at NCPRN. Addiction does not have to be the end of your career or the end of your life. NCPRN is confidential and can be the beginning of a lasting recovery.

The qualities of our Board that I believe give it strength are the members' decision-making process and proactive nature. The decisions the Board is faced with making are often tough ones. The Board is not afraid to take an unpopular position when our members know it is the right thing to do, such as our action last year against Canadian storefront pharmacies. We have demonstrated the ability to engage in constructive dialogue, often disagree--sometimes strongly--and ultimately reach a decision that we can all support.

While the North Carolina Board of Pharmacy is prohibited from lobbying, we have been proactive in speaking out against state and federal legislation that stands to threaten patient safety. A very recent example of that are the broadcast letters we sent to US Senators and Congressmen alerting them to the potentially emergent situations that would be created by pharmacy closings forced at the hands of Medicare Part D and Medicaid reimbursement changes. Compromised access to care is a direct threat to public safety, which is fully within the responsibility of the Board.

Passage of Rules to enable pharmacist authority to administer vaccines and the Clinical Pharmacist Practitioner Act are examples of how this and previous Boards have exhibited a proactive nature in practice-related issues. We continue to work closely with the North Carolina Medical Board to further enhance these opportunities.

Review of each of the Rules that have gone into effect over the past several years provides clear evidence of the Board's commitment to safeguard the health and welfare of North Carolinians. Other common threads are to make the work place and processes that occur within the workplace safer for practice; to enable better support of the pharmacist's role by the technician; and to ensure quality pharmacy practice by reassessing competency of those who have been away from practice for an extended period, as well as reevaluating Rules that pertain to specialty areas of practice such as compounding and nuclear pharmacy.

As a regulatory body, with all of the associated responsibilities, the North Carolina Board of Pharmacy is fortunate to be part of a very unique pharmacy community. North Carolina has always been recognized nationally for the strength of our practitioners, our innovation, and our unparalleled ability to work together-Board, Schools, NCAP, In-

dependents, ACP, Chains, Hospitals, Retail Merchants Association, and NC Mutual-despite our unique interests. My overreaching goal for our Board is to continue to strengthen these valuable relationships that differentiate us and work together to advance the practice of pharmacy while fulfilling our charge to safeguard the public health and welfare.

Public Perspective

by J. Parker Chesson, Jr., PhD
Public Member
North Carolina Board of Pharmacy

I am the public member on the Board of Pharmacy. Unlike my colleagues on the Board, who are elected by their peers, the public member is appointed by the Governor of North Carolina. My term started in May 2005. I am not a pharmacist, having spent most of my career in the North Carolina Community College System - first as a biology teacher at College of The Albemarle in Elizabeth City and also as the college's president for 17 years. I then served as executive vice president of the North Carolina Community College System for four years and headed the North Carolina Employment Security Commission from 1996-2000. Since then, I have worked as a consultant on several higher education studies and assisted several community college boards of trustees in selecting a new president.

In recent years, I have assisted several governing boards in conducting retreats. A few years ago, a friend on the Board of Pharmacy asked me to facilitate a retreat session for the Board. I spent considerable time planning for that session, including studying the purpose of the Board and the way it operated. This was not a difficult assignment, since my oldest daughter is a pharmacist. My biology background has always made me interested in health-related subjects, and my administrative experience over the years exposed me to organizational and regulatory issues.

In early 2005, I received an inquiry asking me if I might be interested in the public seat on the Board. A short time later, I was appointed by Governor Mike Easley to a five-year term.

Before ever being sworn in as a member, I decided that I would not try to become a "pharmacist" during my time on the Board. There is no way I can learn the subject matter. One of the challenges has been learning another set of acronyms! I thought that education had set a record for acronyms, but it is now clear that the field of pharmacy and healthcare far exceeds the education field.

State law mandates that the North Carolina Board of Pharmacy's overall goal is to protect the public's health, safety, and welfare in the practice of pharmacy. As the public member, I will certainly let that be my guide as the Board discusses, deliberates, and makes decisions on matters of great importance to pharmacists, pharmacies, and consumers of medications.

Several people have asked me what have been the surprises about my service on the Board. Before listing a few surprises or things that have been unexpected, let me say that I have no regrets about serving on the Board. It has been very rewarding, with many substantive issues always being before the Board. One thing I knew nothing about prior to coming on the Board was the North Carolina Pharmacist Recovery Network (NCPRN). The surprise for me has been the frequency with which professionals are before the Board for deliberations on reinstatement of a license after revocation due to substance abuse, diversion, etc. The general public does not have a feel for the trap some people can fall into as a result of the collision of emotional and personal stresses and readily accessible drugs, with dire and life altering consequences for the professional. These things do happen - and the NCPRN program is a very positive assistive network for those who want to get back to some degree of normalcy in the practice of pharmacy and in life in general. Bottom line - I am a big supporter of this program.

Another revelation has been learning about the various types of pharmacy practices such as independent pharmacies, chain pharmacies, hospital pharmacies, etc. Each of these operates under a somewhat different type of business plan and each has its own operating style. Pharmacists are "behind the counter" in each, but are subject to different pressures and expectations. However, all must conform to the same state and federal laws and regulations of the Board of Pharmacy.

Another thing I have learned, and which all practicing pharmacists should appreciate, is the large amount of time that Board members must devote to their "voluntary" service. It is time consuming for all of us. I have been very impressed with the dedication of my fellow Board members, all of

Turning Lives Around

by Jack Watts, RPh
Thirteen Year Member, North Carolina Board of Pharmacy

The General Assembly of North Carolina finds that mandatory licensure of all who engage in the practice of pharmacy is necessary to insure minimum standards of competency and to protect the public from those who might otherwise present danger to the public health, safety and welfare.

When I was elected to the Board of Pharmacy the above statute was pointed out to me with emphasis on "protect the public." This I always tried to do and be fair with my fellow pharmacist sitting in front of me for a violation of NC pharmacy law.

In many cases a pharmacist's license had to be suspended. As you know, this meant taking their livelihood away. Many nights I would go home and think about the case I had heard. One particular case took two days to hear and there were three attorneys present for the defendant. I was President at the time and had to conduct the meeting "acting as judge." After the case had been resolved the three attorneys came up to me and said "Young man, we sure did like the way you conducted this meeting." My reply to the three attorneys was "I have been watching a lot of reruns of Perry Mason."

After passing judgment in a case before the Board I would always ask the defendant, "Do you think I was fair with you and your problem?" The answer was always "Yes, Jack, I sure do think you were fair." After all these years I still see some of these pharmacists and they come up to me and thank me for helping them turn their lives around.

The North Carolina Board of Pharmacy is unique in that each member gets the opportunity to serve as president for one year. It was my pleasure to serve several times as president.

whom are full-time, practicing pharmacists.

I had the pleasure of serving as the chair of the Board's search committee that just completed a very successful search for a new Executive Director. David Work's exemplary service for 30 years has been widely recognized across this state and the nation. I had great trepidations about our ability to bring in a successor who would continue David's work and carry it to even higher levels of accomplishment. I am very proud of the Board's ability to attract and employ someone with Jay Campbell's expertise, knowledge, and experience. Being able to do this is, in my opinion, a tribute to the respect people across this state and the nation have for the North Carolina Board of Pharmacy. All of us are looking forward to working with Jay in the coming months and years. There is much to do. I am confident that Jay Campbell will be a valuable asset to the practice of pharmacy in North Carolina for many years.

I bring to my service on the Board of Pharmacy some degree of experience in, and a great deal of interest in, the impact of technology on education, the work place, and society in general. The Internet, Web-based applications, networked computers, and rapidly evolving software applications - all of these have radically changed the way we do work, spend leisure time, and communicate with each other. As broadband connections become commonplace to our homes and almost required in most workplaces, we are going to see these technologies having an increasing impact on all of us. I frequently tell my colleagues in education that it is hard to envision the impact these technologies will have on the delivery of education services.

It is obvious that technology is having a great impact on healthcare, including the practice of pharmacy. In my opinion, this will increase dramatically in the future. There are many jobs in the pharmacy and pharmaceutical area that could be directly impacted by the outsourcing pressures that other occupations are now experiencing, such of financial services, help desk services, and many others. I certainly do not know where this trend will end, but I am very confident that the Board of Pharmacy will be grappling with these types of issues in the future.

I am very appreciative of the opportunity to serve as a member of the North Carolina Board of Pharmacy and, indirectly, the field of pharmacy. I look forward to working with the pharmacy community during the next few years.

Board Rulemaking

by Denise Stanford
Rulemaking Coordinator
North Carolina Board of Pharmacy
Partner in the law firm of Bailey & Dixon, LLP

The Board of Pharmacy (Board) is empowered by the legislature to adopt rules for the performance of its duties. There are three different types of rules that the Board may adopt – permanent, temporary, and emergency rules.

Permanent Rules

The most typical type of rules adopted by the Board are permanent rules. Before adopting a permanent rule, the Board must publish the proposed text of the rule or proposed changes to an existing rule in the North Carolina Register (NC Register). The NC Register is published by the North Carolina Office of Administrative Hearings (OAH), Rule Division. The NC Register may be accessed online at www.ncoah.com/rules/register.

Following publication in the NC Register, the Board must accept written comments from the public on the proposed text for a period of 60 days before adopting the final language of the rule. The Board may hold a public hearing on the rules. If a public hearing is held, the Board must publish the date, time, and place of the hearing in the NC Register. At the public hearing, the public may submit written or oral comments on the proposed rule changes. The Board must consider fully all written and oral comments received. After the Board adopts final language, the rule must be submitted to the Rules Review Commission for review. If there are no objections to the rule, it will become effective on the first day of the month following the month the rule is approved by the RRC. The rule is then published in the North Carolina Administrative Code (Code). The Code may be accessed via the OAH website at www.ncoah.com/rules.

Temporary Rules

Occasionally, the Board will adopt temporary rules. The Board may adopt temporary rules if it finds that adherence to the notice of hearing requirements of the permanent rulemaking process would be contrary to the public interest and that the immediate adoption is required because of certain reasons, as spelled out by statute. Some of these reasons may include: (1) a serious and unforeseen threat to the public health, safety, or welfare, (2) the effective date of a recent act of the General Assembly or the United States Congress, or (3) a recent court order. In order to adopt a temporary rule, the Board must publish the rule and a notice of public hearing on the OAH Web site. The Board must also notify interested parties of its intent to adopt a temporary rule and of the public hearing and accept written comments on the proposed temporary rules for at least 15 business days prior to adoption of the temporary rule. The Board must also hold a public hearing on the proposed temporary rule. After adopting the temporary rule, the Board must submit the temporary rule to the RRC for review along with its written statement of the Board's findings of need for the rule. Once approved by the RRC, the rule is submitted to the Codifier of Rules at OAH and must be entered into the NC Administrative Code on the sixth business day following receipt. The temporary rule becomes effective when it is entered into the Code. The temporary rule is only effective for approximately nine months. The Board must proceed through the permanent rulemaking requirements to adopt a permanent rule to take the place of the temporary rule.

Emergency Rules

Emergency rules can only be adopted when immediate adoption of the rule is required by a serious and unforeseen threat to the public health or safety. When an agency adopts an emergency rule, it must simultaneously initiate temporary rulemaking. The emergency rule is submitted directly to the Codifier of Rules at OAH along with a written statement of the Board's findings of need for the rule. If the Codifier determines that the statement meets the criteria, he must enter the rule in the Code on the sixth business day following approval. The emergency rule becomes effective on the date it is entered into the Code. The emergency rule is only effective for 60 days. Either a temporary rule or permanent rule must be adopted to take its place.

All licensees must comply with rules adopted by the Board. Therefore, it is important to give your input when the Board is accepting comments and to keep up with rule changes.

Recollections

by W.H. (Bill) Randall, RPh
Board Member 1965-1996
Board President 7 years
Campbell University Infirmary
Pharmacy Manager

How do you put in words 31 years of associations with some of the best people in the world? You remember the good things about the other Board members and staff, not the bad that came about in cases heard by the Board of Pharmacy. You remember how hard the Board members would argue during hearings and how they were family as soon as a decision was made. Each had their ideas but once a decision was made, it was the decision of the Board of Pharmacy. They had no pre-formed ideas on what should be done. They were for protection of the public and betterment of pharmacy practice, not just in North Carolina but anywhere in the world. They felt they were a good Board and in 1995 were recognized with the Fred Mahafie Award as the outstanding Board in America. They were proud of the award but felt the Board as a group, with the leadership of Dave Work, earned it. It was great to be recognized by your peers.

Getting older has its benefits. I am the only one still alive who was there when Fred Eckel was hired with Plan of Pharmacy Assistance to improve Hospital Pharmacy in North Carolina. Also, I am the only one still alive who voted to bring David Work back to North Carolina to lead the North Carolina Board of Pharmacy for 30 great years. Working for 31years with the leadership of H. C. McAllister and David Work was a privilege that few people have had the opportunity to enjoy. These were two men who had ideas for pharmacy that they were willing to spend many hours trying to achieve. North Carolina is better because of their work.

It is hard to say what the most significant activity was during the years. Rewriting the Pharmacy Act in the early 1980's comes to mind. This allowed many of the changes that we now see and gives more freedom to the pharmacist to participate in a multi-cultured practice with other professionals. It seemed that David Work had the belief that if it was not prohibited, we should find a way to allow what was good for the patient and the pharmacist. This enabled the Board of Pharmacy to set rules that established many of the practice acts that are allowed today. The creation of the Leaders Forum to allow more discussion among different groups involved in pharmacy is also remembered.

Changes have dominated the activities during the years. When I attended pharmacy school students were about 10 percent female. During the years, I watched this change to more than 50 percent female. Now more than 50 percent of pharmacists in North Carolina are female. They have been good for pharmacy. I served with the first female Board member. Now we have two female Board members doing a good job of serving the profession.

Training of Pharmacy Interns and Externs has changed from the old days when daily notebooks were required to document training onsite and Board Members graded these. I know as a Board Member it was great to not have to wade through pages of "No unusual prescriptions today." You were almost happy to get the student, in all innocence, who stated "Today, I worked by myself for the first time as 'Mr. Blank' took off for the day." Another violation from a notebook, "Today our local paregoric addict came by to buy paregoric." Today, all training is done under leadership of the Schools of Pharmacy.

The days of Board members preparing a State Board Exam and spending three days giving the exam and many days grading has been replaced by computer generated exams, quickly scored and results released. The old wet labs exam is long past. You still wonder if knowledge taught can be used unless it is demonstrated. You are always amazed at how great the students are and yet you always have some bad apples. How do you correct and save these few? I know that it was a shock the first time one of your classmates appeared before the Board for some violation. Then again it was a shock to see the child of a classmate seated in the hearing room, charged with violating Pharmacy Law. All these had to be decided on the basis of evidence presented and not on whom you knew. These were the bad moments.

The good moments were all the opportunities to associate with the Board members and staff during the years. I had the privilege of working with some of the most dedicated people in North Carolina.

We all wondered how the public members would fit in after they were added to the Board. They all came in with open minds and questions that Board members had not thought about so they added to the effectiveness of the Board.

One group that needs special recognition was the staff of investigators. We had a very special group during the years. All different but all dedicated. They had no ax to grind, they just wanted things to go right and according to regulations.

After finishing pharmacy school and becoming licensed, I had no intentions of serving on the Board of Pharmacy. I wished to be involved in the state association. However, one night, I got a visit from a group of pharmacists asking me to run for the Board of Pharmacy. I told them I had no desire for that position but they urged me to think about running. I told them I would let them know after discussing it with my partners and family. Little did I know how that decision would affect the rest of my pharmacy career. I was elected and reelected six times. It became a passion to see North Carolina Pharmacy be number one. It was a privilege to have had a part in that dream, working with some very dedicated people.

I do not know what the future holds but I feel as long as the members of the profession elect their Board members, the North Carolina Board of Pharmacy will remain strong. They will do the task assigned by the State of North Carolina. They will protect the public as well as lead pharmacy into new areas of service. It is all about the patient and their right to enjoy good health service. This is the intention of the members of the North Carolina Board of Pharmacy.

calendar

March 4: ***Immunization Certificate Program,*** Institute of Pharmacy (NCAP office), Chapel Hill
March 5-6: ***Community Care Practice Forum Meeting,*** Chapel Hill Sheraton
March 23-24: ***Chronic Care Practice Forum Meeting,*** University Hilton, Charlotte
April 8: ***Student Pharmacist Leaders Conference,*** FirstHealth, Pinehurst, NC
April 19: ***Open House,*** Institute of Pharmacy, Chapel Hill
April 24-26: ***Acute Care Practice Forum Meeting,*** Sheraton Four Seasons, Greensboro
April 30: ***Update on NC Pharmacy,*** AHEC Airport Training Facility, Charlotte
May 4: ***Update on NC Pharmacy,*** Mountain AHEC, Asheville
May 7: ***Update on NC Pharmacy,*** Moses Cone Hospital, Greensboro AHEC
May 8: ***Update on NC Pharmacy,*** Andrews Conference Center, Wake Med Education Facility, Raleigh
May 9: ***Update on NC Pharmacy,*** Eastern AHEC, Monroe Center, Greenville
May 11: ***Update on NC Pharmacy,*** Cape Fear Valley Medical Center, Education Center, Fayetteville
July 14: ***Residents Leadership Conference.*** Friday Center, Chapel Hill
Sept. 8-10: ***Pharmacy Practice Seminar*** Wilmington, NC
Oct. 22-24: ***NCAP Annual Convention,*** Sheraton Imperial, RTP, NC

Quality Assurance Task Force Meets

NCAP's newly created Quality Assurance Task Force held their first meeting January 30 at the NCAP office. The group will give recommendations to NCAP on what can be done to promote a culture of safety and quality within NC pharmacy. It will also assess what is currently happening in NC regarding quality and safety in pharmacy. The Task Force will prioritize the opportunities and needs to give the NCAP Board some direction on what activities should be implemented. John Kessler and Bob Cisneros co-chair this Task Force. Carole Cranor, Associate Director of the North Carolina Center for Pharmaceutical Care, is providing staff support for the group. Twenty pharmacists from a cross section of practice settings have agreed to participate and are as follows: Gray Stewart, Tim Giddens, Rob Bizzel, Dave Moody, Steve Novak, Colleen Gresham, Ross Brickely, Bill Harris, Ron Small, Rebecca Chater, Tim Duncan, Mike James, Andy Ellen, Dave Catalano, Rowell Daniels, Parker Chesson, Trista Pfeffenberger, Lynn Eschenbacher, and Jay Campbell.

Errors of the Heart

by Bob Cisneros

Richard Friedman, a physician, wrote an article recently for the *New York Times* in which he said, "Most patients will forgive their doctor for an error of the head, but rarely for one of the heart."[1] His focus was on the importance of communicating with patients after an error. Friedman discussed the power an apology can have. The article is as pertinent for pharmacists as it is for physicians.

Much has been written about the need for better medication error reporting. How do we know if a problem exists (or the extent of it) if no one is reporting the problem? If an organization "shoots" messengers bearing bad news, who would want to report an error? Normally, when error reporting is discussed, the emphasis is on the reporting taking place within an organization or reporting done for agencies, such as a State Board of Pharmacy.

But what about reporting to the patient? If a patient is a victim of an error, how much should be disclosed about the error to the patient? Is it best to watch our words, tiptoe around the facts and never admit that an error has occurred for "legal reasons?" Is the fear of a law suit forcing pharmacists to compromise their own ethical principles in dealing with a patient after an error? How ethical is a policy of "never admitting that a mistake has been made" when the APhA Code of Ethics specifically states, *"A pharmacist has a duty to tell the truth and to act with conviction of conscience."*[2] Manser and Staender report that "the medical literature is unambiguous with regard to the ethical duty to disclose."[3(p 732)]

The subject of apology to the patient has begun receiving much attention. Is it ok to apologize to a patient or will that increase the risks of a law suit?

What Research Has Found

Several studies have been conducted which gathered information regarding patient attitudes about medical errors. The findings provide us with insight into the importance of communicating with our own patients after an error.

Gallagher et al[4] studied both patient and physician attitudes regarding the sharing of information after a medical error. The study utilized physician and patient focus groups. Differences found between physician and patient attitudes included:

(1) An apology was felt to be desirable by patients but physicians believed that making an apology would increase their legal risks.

(2) Patients preferred a broad definition of "error," while physicians preferred a much narrower definition.

(3) Patients wanted to know about all errors that caused harm, including near misses. Physicians thought there should be some exceptions and had concerns about the wording of this information. [4]

Further, patients wanted error details regarding exactly what happened and why, the potential for harm, and how the error would be prevented in the future. While "honesty" and "compassion" seem to be terms missing in many discussions of medication errors, these qualities were important considerations to the patients in this study. The authors reported that "many patients said they would be less upset if the physicians disclosed the error honestly and compassionately and apologized. Patients thought that explanations of the error that were incomplete or evasive would increase their distress."[4 (p 1005)]

The authors advised physicians that, at a minimum, the patient should know that an error did indeed occur, exactly how and why the error happened and that an apology should be given. [4] Perhaps good advice for us to follow in pharmacy too?

Duclos and colleagues[5] studied similar patient perceptions, utilizing focus groups of patients who had been involved in malpractice insurance cases. The results also showed that communication was an important issue. Lack of information led many patients to feel that they were in an adversarial relationship with the physician. The study reported that "frustration from poor information about their situation led to feelings of anger and a perceived need for battles or conflict."[5(p 482)] Perhaps we could go one step further and speculate that often this frustration actually leads to legal action.

It was also found that when communication was perceived by the patient as good, the patient's relationship with the physician was continued even after the event. Characteristics of good communication, according to the subjects in the study, included: caring and honesty from the health care provider, quick response, and the provider spending time with the patient, assuming responsibility for what happened and providing reassurance. As one patient reported, "Everyone makes mistakes. My physician made a mistake but he was trying to do the best possible job he could and a mistake unfortunately happened."[5(p 482)]

Patient perceptions of poor communication experiences included: a lack of communication, no admission of a mistake, not showing respect to the patient, not caring, and not taking the time to explain things. Both Gallagher et al[4] and Duclos et al[5] agreed that quality communication was important to the patient.

Other studies have also supported the importance of communication and the relationship between poor communication and litigation.[6,7] Lamb discussed an interview she had with patients who were in the process of suing their doctors:

They commonly spoke of feeling betrayed by clinicians they had previously trusted because, they said, their doctors had been unwilling to talk to them openly about what had occurred. They said that mistakes happen, but they expected an honest and "human" response. Some of the patients were suing because they had unanswered questions.[8(p 4)]

Again, these studies did not specifically involve pharmacist errors. It is difficult to ignore the significance of these thoughts in regards to our own pharmacy practices though. What would our patients say about us? Are we cultivating positive relationships?

The Power of Apology

The desirability of an apology by patients has been identified. Though saying "I'm sorry" doesn't quite seem to fit into today's lawsuit oriented society, evidence suggests that the lack of a sincere apology may be a factor in a patient's decision to pursue legal action.[6] An apology is often quite difficult to make, regardless of the reason for the apology, but it can have a powerful effect. Frenkel and Liebman editorialized in the *Annals of Internal Medicine*: "Apologies have a potential for healing that is matched only by the difficulty most people have in offering them."[9(p 482)]

In Friedman's *New York Times* article, he noted the fear of lawsuits that grip most

professionals, but mentioned that when apologies are made for errors, the chances of law suits may be lessened. He encouraged doctors to let patients know about errors because the act of apology "humanizes them [doctors] and builds trust." [1]

The "Sorry Works! Coalition" is a new organization that has been formed (www.sorryworks.net). Its members represent a variety of backgrounds and include physicians and lawyers. The group believes in full disclosure and apologies after an adverse event. It believes in the importance of an immediate root cause analysis following an adverse event to determine if the quality of care was at fault. If so, the coalition believes that apologies should be made, an explanation of what happened given as well as how it will be prevented in future, and if appropriate a fair offer of compensation offered. The Web site provides numerous links to related information.

"Apology laws" now exist in several states. According to Cohen, the first such law was enacted in 2003 in Colorado.[10] The law enables a health professional to apologize for an error without fear of it being considered an admission of guilt or used against him/her if legal action is pursued. Other states have had similar laws regarding expressions of sympathy, but no state had previously addressed an actual apology for an error. Cohen stated that "the critical issue is usually not whether an apology will prevent all legal recourse but rather how it will influence the character of that recourse." [10(p.23)] A just financial compensation may be warranted in many cases of error. But will compensation be guided by what is fair and just or by anger and a desire for revenge? Evidence suggests that full disclosure and a sincere apology may influence this.[10]

Being Human

In the workplace, it is absolutely mandatory to be familiar with policies and procedures regarding medication errors. One's employment (and insurance) could be jeopardized by knowingly disregarding any policy. This should not preclude a critical review of such policies though. Let's consider for a moment how we would want to be treated if we or a family member were the victim of an error. Wouldn't we want to know what happened and why? Wouldn't we expect a sincere apology?

We are not perfect. Errors of the head unfortunately happen. Errors of the heart shouldn't. ❖

About the Author...
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Pharmacy Technician Survey Study

Purpose

This survey attempts to obtain information about the general pay scales of pharmacy technicians with and without board certification through examination (CPhT designation). Accessory and background information was compiled that attempts to probe how technicians are being used and what potential opportunities there are for expanding technician responsibilities in various settings.

This survey does not attempt to show statistical differences in payment scale across various practice sites, but does attempt to obtain information on how technicians are reimbursed along with some of the potential influencing factors that determine the payment scale. This survey was also designed to obtain pharmacist opinion on technician responsibility and ability.

Methods

A survey of approximately 12 questions were administered either by telephone or fax to 120 randomized pharmacies (30 of each hospital, chain retail, independent retail, and compounding retail) throughout North Carolina during the month of July 2005 at the NC Board of Pharmacy. Fifty total pharmacists responded from all of the types of pharmacy practice sites. The numerical variables were tabulated and averaged over the total number of respondents. A subanalysis was conducted looking at the same averages per practice site. The short answer questions were summarized and listed in a bulleted format and are summarized in the conclusion section.

Results

Pharmacy Technician Reimbursement Overall:

	Average Pay ($)	Standard Deviation
CPhT (Board Certified)	10.86	1.86
No Experience	8.28	2.14
1+ Years of Experience	11.50	4.37
Lowest (ever heard)	6.34	1.04
Highest (ever heard)	14.83	2.60

Table 1

Figure 1

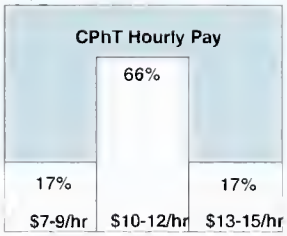
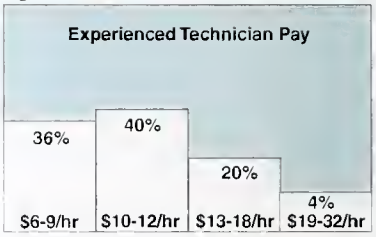


Figure 2

Figure 3



Pharmacy Technician Reimbursement per Practice Site:

	CPhT Average Pay	No Experience	1+ Years of Experience
Overall (N=50)	10.86 ± 1.86	8.28 ± 2.14	11.50 ± 4.37
Hospital (n=7)	10.25 ± 0.50	11.12 ± 2.50	20.21 ± 6.76
Chain (n=17)	10.10 ± 1.68	7.19 ± 1.11	10.45 ± 2.12
Independent Retail (n=16)	10.96 ± 0.94	7.54 ± 1.16	10.09 ± 2.47
Compounding (n=10)	11.94 ± 0.94	9.39 ± 2.32	10.94 ± 3.10
Independent Total (n=26)	11.33 ± 2.25	8.24 ± 1.88	10.65 ± 2.66

Table 2

Pharmacy Demographics: Technicians, Pharmacists and 3rd party training/ability:

	Average # CPhTs	Average # Technicians	Average # Pharmacists	Amount of help with 3rd party payment*
Overall (N=50)	3.2	4.8	2.9	2.15
Hospital (n=7)	6.2	9.3	6.4	3.71
Chain (n=17)	2.9	5.1	2.5	1.69
Independent Retail (n=16)	2.1	3.7	2.0	2.31
Compounding (n=10)	2.4	2.8	2.3	1.38
Independent Total (n=26)	2.3	3.4	2.1	2.00

Table 3

*How much are your technicians involved in 3rd party payments:

1. Fully capable of handling over 90% of 3rd party procedures/payments/problems
2. Moderately capable of handling about 50% of 3rd party procedures/payments/problems
3. Mildly capable of handling about 25% of 3rd party procedures/payments/problems
4. Not trained or able to deal with 3rd party procedures/payments/problems

Conclusions

The average per hour salary for a technician with 1 or more years of experience ($11.50 ± 4.37) seems to be a greater factor in hourly pay than certification alone ($10.86 ± 1.86). Hospital pharmacy tends to hold the most significant factor in the technician payment scale as experience, noting an approximate $10 more reimbursement for experience vs. certification. Hospital pharmacy in this survey is also somewhat inconsistent with the rest of the practice sites in that the new hire without experience makes slightly more than the certified CPhT designee. This may be due to sample size and potentially the importance of specific training at each individual hospital site. Overall, compounding pharmacies pay their technicians the most, about $2 more than their retail counterparts. Other observations are: compounding pharmacies tend to pay the most for board certification ($11.94 ± 0.94 vs. $10.96 independent vs. chain $10.10), there is a trend for chain stores to pay technicians without experience about $0.25 less than independent retail ($7.19 ± 1.11 vs. $7.54 ± 1.16), and hospital was the least involved with 3rd party (3.71 vs. 2.31 for independent retail only).

Overall, 66% of certified technicians earn $10-$12 whereas only 40% of experienced technicians make the same amount. Also, 17% of the certified technicians make more than $10-$12, whereas 24% of experienced technicians make more than this same range. The largest section of the inexperienced technicians (42%) are paid between $5.15-$7 and only 8% were paid between $12-$16. Eighty-three percent of certified technicians make at or above $10, whereas 64% of experienced technicians and only 25% of inexperienced technicians make at or above the $10 mark. Many factors limit the conclusions that can be drawn from these analyses such as sample size, heterogeneity of practice sites, and the standard of living influences within each geographic area of practice.

Across all subjects the average technician was moderately involved in 3rd party payments/problems/procedures being able to handle approximately 50% (2.15). This may be an area of needed education in training of the technician. When asked what suggestions for better utilization of technicians or what types of increased responsibilities would be useful, many pharmacists responded that 3rd party interactions or training would be very useful and may increase the technician salary. When asked what other abilities do technicians have at your site but may not occur at others, pharmacists replied that technicians handle: over-the-counter medication and first aid counseling, expired/recalled drug products, patient prescription assistance programs, bar coding, marketing and advertisements, community health fairs (diabetes, sunscreen, immunization, etc.), durable medical equipment sales, and some clinical services (blood glucose, blood pressure, cholesterol, asthma, etc.). When asked about other opinions or comments regarding pharmacy technicians, many interesting comments were revealed such as the need for a definition of "technician practice" and the possibility of licensure over certification. Also, there were differing opinions concerning a technician's ability to take prescriptions over the phone "since most prescription calls are not from the primary care provider, but from a secretary or nurse." One pharmacist even commented on how technicians should be able to counsel patients on 1-2 points about the prescription such as the information that is on the label or in the pamphlet handout. Lastly, and possibly the most concerning comment was "Do pharmacists realize that the profession is being taken away?" This comment may be in fear of the increasing reliance and responsibility on the technician or possibly due to the fear of automation and the increasing prevalence of mail order pharmacies. Whatever reason(s), this pharmacist has for this belief presents the possibility that other pharmacists may feel the same and thus should be explored.

Many factors influence the salary of the pharmacy technician. When asked what factors influence the payment scale, pharmacists replied with much expected comments like: work ethic, experience, communication skills, attitude, and dependability. Overall, technicians are paid fairly comparable per practice site ranging from about $7.50-$11.00 with the highest potential for income in the hospital sector, which could be expected due to the variability of technician duties across practice sites. Most pharmacists concluded that technicians are probably not being paid enough for what they do and most would like to pay more. ❖

About the Author...

Bill Bryan is a 4th year pharmacy student at UNC-CH and undertook this project during his rotation at the North Carolina Board of Pharmacy. He can be reached at bbryan@email.unc.edu

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We would like to express our appreciation to the following members and friends who contributed to the 2005 President's Club. Contributions received with membership renewals or during 2006 will be recognized on the 2006 President's Club list.

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2005 Building Remodeling Fund Contributors

The Institute of Pharmacy, which houses NCAP, is undergoing renovations thanks to the following individuals who contributed to the 2005 Building Remodeling Fund. Working together, we met the $25,000 challenge for 2005 and received a two-to-one match of $50,000 from the Pharmacy Network Foundation. A special thanks goes to Jack Watts who is chairing the campaign. We have received another challenge for 2006. If you would like to contribute, please contact Linda Goswick at NCAP: 919.967.2237, 800.852.7343, linda@ncpharmacists.org. Your contribution is tax-deductible. We hope that you'll attend our Open House on April 9. See page 5 for details.

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Medicare Partnership Meeting

l to r: Gina Upchurch, Leigh Foushee, Commissioner Long, Ouita Davis, and Mark Gregory.

Several North Carolina pharmacists had the opportunity to visit and listen to CMS Administrator Dr. Mark McClellan, Congressman Robin Hayes, NC Insurance Commissioner James Long, NC Health and Human Services Secretary Carmen Hooker Odom, as well as many other partners across the state, in a Medicare Part D "Partnership Meeting" held at SHIIP Headquarters (Seniors Health Insurance Information Program) in Raleigh on Monday, January 6, 2006. Representing NCAP were Mark Gregory, Ex Officio – Chain Pharmacy, NCAP 2006 Board of Directors and Leigh Foushee, PharmD, Chair – Community Care Practice Forum. Gina Upchurch, RPh, MPH, Executive Director of Senior PHARM*Assist*, and Ouita Davis, Clinical Coordinator with Kroger Pharmacy, were also in attendance. Several leaders from senior-related programs attended including representatives from AARP, Social Security, Cystic Fibrosis and Mental Health Task Forces.

Dr. McClellan thanked everyone there, especially the community pharmacists across the state, for the incredible job they have done insuring NC seniors receive their medication benefits as quickly as possible. He acknowledged what a difficult and time-consuming process Medicare Part D has been thus far, but made it very clear his office is available to answer questions and work through various issues.

Candidates Pass CCGP Exam

NCAP would like to congratulate the following members who have been accredited as Certified Geriatric Pharmacists (CGP) by the Commission for Certification in Geriatric Pharmacy (CCGP): Rebecca A. Parrish of Goldsboro, Holly H. Nunn of Raleigh, and Mark E. Creasman of Brevard. CCGP administered its 17th Certification Examination on November 9 and 12, 2005. A record 184 candidates sat for the exam, of which 163 earned a passing score.

NCAP Election Results

All of the candidates for this year's election received significant support from the membership. NCAP would like to thank all of those who participated. The results are as follows:

NCAP President-Elect – Beth Williams
NCAP Treasurer – Tim Giddens
NCAP Board Member at Large – Regina Schomberg
Acute Care: Chair-Elect – John Kessler
Executive Committee: Dana Blecke, Mary Parker, Trista Pfeiffenberger, Debra Pittman, Al Simmons
ASHP Delegate: Stephen Eckel
Chronic Care:Chair-Elect- Athena Smithwick
Community Care: Chair-Elect – Lori Brown
Executive Committee: - Kelly Klimczak

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